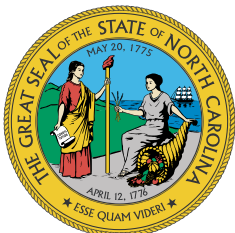




NORTH CAROLINA STATE HEALTH IMPROVEMENT PLAN

*A companion report to Healthy North Carolina 2030: A Path Toward Health
(NCIOM) and the 2019 North Carolina State Health Assessment*



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**
Division of Public Health

2022



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**
Division of Public Health

This plan was prepared by the North Carolina Department of Health and Human Services, Division of Public Health by the State Center for Health Statistics (NC DHHS/DPH). The North Carolina Institute of Medicine (NCIOM) assisted with the 2020 NC State Health Improvement Plan (NC SHIP) and continues to partner with the Division of Public Health in the annual review of both *Healthy North Carolina 2030: A Path Toward Health (HNC 2030)* and the NC SHIP.

NC DHHS/DPH also partners with The Foundation for Health Leadership & Innovation, Inc. and the NC Area Health Education Centers to support Results-Based Accountability™ (RBA).

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The full text of the 2022 NC State Health Improvement Plan may be found at: <https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm>

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June 1, 2022

A JOINT LETTER OF INTRODUCTION FOR THE 2022 NC STATE HEALTH IMPROVEMENT PLAN

Healthy people and healthy communities are the foundation of a thriving, prosperous state. That fact is why we need to ensure every North Carolinian has the opportunity to be healthy, regardless of their race or ethnicity, where they live, or how much money they have.

In 2020, the North Carolina Institute of Medicine and the North Carolina Department of Health and Human Services released *Healthy North Carolina 2030: A Path Toward Health*. This decennial document lays out ambitious goals to improve the health of North Carolinians for the current decade and is intended to mobilize health organizations across the state to work together toward a common set of objectives that can help more North Carolinians have the opportunity to be healthy. We are pleased to present the accompanying 2022 *North Carolina State Health Improvement Plan (NC SHIP)* which charts the path and describes the process to improve the *Healthy North Carolina 2030* indicators.

Like you, we know that common objectives and aligned work are essential for making meaningful, lasting change. Take, for example, the urgent need to reduce North Carolina's infant mortality rate and address the unacceptable fact that black babies in our state are 2.5 times more likely to die before their first birthday than white babies. Medical, educational, economic, environmental and social factors all play a role in infant mortality, such as: does the mother have a safe place to live or food to eat or access to medical care? We want all babies to celebrate their first birthday, but we need a shared goal, an accountable process, and many partners working together to reach that goal. That is what the State Health Improvement Plan lays out.

The *NC SHIP* is complementary to and expands upon the NC DHHS 2021-2023 Strategic Plan as well as NC DHHS's priorities for COVID-19 Recovery: Improving Behavioral Health and Resiliency, Strengthening Child and Family Well-Being, and Building a Strong and Inclusive Workforce.

Many partners join us in the work to improve population health, but we take this opportunity to acknowledge a few that have been a part of the strategic planning since the release of *HNC 2030*. We extend special appreciation to:

- The Foundation for Health Leadership & Innovation (FHLI),
- The North Carolina Area Health Education Centers (NCAHEC), and
- The North Carolina Institute of Medicine (NCIOM).

We encourage you to identify those *Healthy North Carolina 2030* indicators your organization can adopt and become involved in the process through strategic planning. For more information, please contact the *HNC 2030* Resource Center HNC2030@dhhs.nc.gov.

Sincerely,

Mark T. Benton

Mark T. Benton
Deputy Secretary for Health

Elizabeth C. Tilson

Elizabeth Cuervo Tilson, MD, MPH
State Health Director
Chief Medical Officer

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2022 NORTH CAROLINA STATE HEALTH IMPROVEMENT PLAN: AT A GLANCE

The release of each decennial Healthy North Carolina publication triggers a process to establish a series of indicators and goals to improve the health of North Carolinians throughout the decade. *Healthy North Carolina 2030: A Path Toward Health (HNC 2030)* lays out ambitious goals for the 2020-2030 decade and is intended to mobilize and coordinate a broad array of private sector, public sector, and community organizations that can play a role in making North Carolinians healthier. *HNC 2030* leverages the population health model to address the drivers of health that affect health outcomes like quality of life and life expectancy: social and economic factors, health behaviors, physical environment, and clinical care.

The North Carolina State Health Improvement Plan (NC SHIP) builds upon *HNC 2030* to help create a unified approach across multiple stakeholders to drive improvement in the indicators throughout the decade covered by *HNC 2030*. The *NC SHIP* documents are iterative, describe the process for improvement, and report on progress of any improvements. The 2020 *NC SHIP* began to lay out the process and has a deeper dive into the 2030 indicators.

In this document, you will see the activities of and the plan for the Community Council that designs and drives the *NC SHIP*, a strong emphasis on Results-Based Accountability that is the chosen methodology for driving improvement, the introduction of the web-based tool Clear Impact Scorecard which will track progress on the indicators, and a menu of suggested policies, programs, and partners that will help to move the needle.

KEY ELEMENTS

Community Council

Through a series of Community Council meetings held during the last calendar year, 323 multi-sector community partners and stakeholders refined the improvement process and identified initial potential policy options to move the needle on indicators. These policy options will be further prioritized by the Community Council.

To engage wider participation from key stakeholders, each *HNC 2030* indicator will have three Community Council co-leads representing NC DHHS, a non-NC DHHS partner (i.e., other government entity, nonprofit, or academic institution), and a community representative who will coordinate their collective action.

Results-Based Accountability

The *NC SHIP* has adopted Results-Based Accountability (RBA), a disciplined way of thinking and acting to improve entrenched and complex social problems, as the methodology for driving improvement.

NC DHHS, NC Area Health Education Centers, and the Foundation for Health Leadership & Innovation have provided 13 low-cost RBA courses to 217 participants using RBA-certified faculty. Further training opportunities for organizations and partners will continue in 2022.

Clear Impact Scorecard

The web-based tool Clear Impact Scorecard is a performance management and reporting software that mirrors RBA and was introduced statewide in 2021 to promote transparency and shared accountability.

The NC State Health Improvement Plan Scorecard is used to track progress on both the *HNC 2030* indicators and the proposed policies in the *NC SHIP*.

Getting Started: How to use the 2022 NC SHIP for health partners, government officials, and community partners:

- Review the *HNC 2030* metrics and identify which indicators your organization can contribute to their progress.
- Adopt these indicators as part of your strategic planning or other organizational processes for driving change.
- Review “Proposed Policy Initiatives” (pp. 21-25) to identify key actions your organization may take.
- Contact HNC2030@dhhs.nc.gov to get further involved or obtain additional information.
- Monitor the *HNC 2030* and *NC SHIP* Scorecards to track progress.

The 2022 North Carolina State Health Improvement Plan (NC SHIP) describes the process and progress for improving the health of North Carolinians based upon *Healthy North Carolina 2030: A Path Toward Health (HNC 2030)*. This process is broader than, but complementary and supportive of the NC DHHS Strategic Planning process.

The document is divided into three sections:

SECTION I – Background & Annual Update

SECTION II – HNC 2030 Indicators

SECTION III – References & Appendices

SECTION I provides an overview of the population health framework guiding the selection of 21 headline indicators in the HNC 2030 report. The basic characteristics and language of Results-Based Accountability (RBA) are also introduced. RBA separates population accountability from performance accountability using data to show how we are making people better off because of our work.

Readers will find a description of the NC SHIP iterative process for building partnerships, identifying what works, and developing strategies for changing policies. In addition to the annual NC SHIP report, community members and partnering organizations can access the web-based tool, Clear Impact Scorecard, for a real-time update on progress (<https://app.resultsscorecard.com/Scorecard/Embed/75778>). The tool tells the story of how state and local health departments, and their partners move from talk to action and implement the programs that work while monitoring performance. The NC SHIP strives to “Do the Right Things and Do Them Well.”

Finally, this section provides a timeline of the NC SHIP three phases and proposed policy initiatives.

SECTION II applies RBA and “Turn the Curve Thinking” to each of the 21 headline indicators.

Result Statements:	What are the quality-of-life conditions we want for the children, adults and families who live in North Carolina?
Indicators:	How can we measure these conditions? How are we doing on the most important measures?
Partners:	Who are the partners that have a role to play in doing better?
What Works:	What can be done better?
Action Plan:	What do we propose to do? (Adapted from Friedman, 2015)

THE NC SHIP RESULT

“All people in North Carolina to have equitable opportunities for health, education, and economic stability throughout the lifespan.”

Consistent with RBA, the NC SHIP uses trend data to determine if we are going in the right direction on each of our most important population indicators. The COVID-19 pandemic impacted every aspect of data collection and analysis and therefore readers should exercise caution when comparing data from 2020 to 2021.

SECTION III documents references for both the data and the narrative used throughout the report. Moreover, the appendices supplement and summarize HNC 2030 data and upcoming RBA training opportunities through NC Area Health Education Centers (NC AHEC).

The NC SHIP highlights one of the key characteristics of RBA, “Ends to Means” by concluding with an artistic rendition of what a Healthy North Carolina could look like. The custom artwork, created by Kim Ballentine of Raleigh and Morehead City, is used in the RBA course to help participants think about the quality-of-life factors that make it possible for **“all people in North Carolina to have equitable opportunities for health, education, and economic stability throughout the lifespan.” (2022 NC SHIP Scorecard)**

If you are interested in participating/contributing to this work, please contact the HNC 2030 Resource Center at HNC2030@dhhs.nc.gov.

SNAPSHOT OF 2021 COMMUNITY COUNCIL ACTIVITIES

NC SHIP includes an annual review process by the Community Council. While the process worked well, especially during the COVID-19 response, there are opportunities for improvement. NC Division of Public Health (DPH) leadership found that council representation for more traditional public health indicators was strong, but there was less involvement in indicators related to education, incarceration, the built environment, primary care, and the uninsured. Many stakeholders participated in the symposia, but most came to listen and learn, not to advise on policy, practice, and programs. DPH will work with partners to review and revise the process for 2023.

REGISTER NOW!
Annual Review of the
**N.C. STATE HEALTH
IMPROVEMENT
PLAN (NC SHIP)**

THURSDAY, JULY 29, 2021
8:30 A.M. – 4:30 P.M.
100% Virtual

WHO IS INVITED?
NC SHIP Community Council Members, NC DHHS/Division of Public Health Management Team, Section Leaders, Branch Heads, and Diversity, Equity, and Inclusion Council Members.

WHAT IS THE PURPOSE OF THE COMMUNITY AND STAKEHOLDER SYMPOSIA?
The NC SHIP Community Council members, assisted by leaders from the NC DHHS/Division of Public Health, will review the 2020 NC SHIP using the Results-Based Accountability framework. The Community Council members will examine the current recommendations for improving health of persons in North Carolina by looking at the data indicators, the story behind the curve, what works, and partners that can help us do the right things and do them well. Knowing that the pandemic limited the number of community partners in the 2020 planning process, the Community Council will nominate new partners to participate in the nine symposia that follow the annual meeting.

NEED MORE INFORMATION?
Contact Ikisha Brothers at ibrothers@ncsu.edu
NC SHIP Community Council Members who are not compensated by a sponsoring agency to participate may request a small stipend to offset the cost of participation. Details will be provided upon request.

HOW DO I REGISTER?

- Please reserve your space by registering before **Friday, July 23, 2021.**
- You must have a current MyAHEC account to register.
- There is no registration fee.
- Be on time – the waiting room opens at 8:15 a.m. and we help resolve any technical issues.

CLICK HERE TO REGISTER

NC SHIP COMMUNITY COUNCIL MEETINGS

July 29, 2021 – 29 Participants

August - September, 2021 - 323 Participants

2020 NC SHIP Participants PLUS DPH Program Leads 132+ INVITEES	July 29, 2021 29 participants 22% OF INVITEES	Nine Additional Community and Stakeholder Symposia August - September, 2021 323 PARTICIPANTS
COMMUNITY COUNCIL SESSIONS WITH NC DHHS/DPH PARTICIPATION <ul style="list-style-type: none"> • Access to Healthy Foods • Sugar Sweetened Beverage • HIV Diagnosis • Early Prenatal Care • Teen Pregnancy • Infant Mortality • Drug Overdose Deaths • Tobacco Use • Life Expectancy 	COMMUNITY COUNCIL SESSIONS WITHOUT NC DHHS/DPH PARTICIPATION <ul style="list-style-type: none"> • Poverty • Unemployment • School Suspensions • Incarceration • Exercise Opportunities • Severe Housing Problems • Suicide • Excessive Drinking • Primary Care Providers • Uninsured • Third Grade Reading • Adverse Childhood Experiences 	COMMUNITY COUNCIL SESSIONS WITH EXTERNAL PARTNER PARTICIPATION <ul style="list-style-type: none"> • Severe Housing Problems • Suicide • Excessive Drinking • Primary Care Providers • Uninsured • Third Grade Reading • Adverse Childhood Experiences

How do we continue to include and expand community council/partners in defining priorities and policies and implementing recommendations?

**WHERE ARE WE CURRENTLY?
WHO HAS BEEN INVOLVED?**

- *HNC 2030* Annually Reviewed
- Participants
 - Prior participation in *HNC 2030* Work Groups / Task Forces
 - Prior participation in the *2020 NC SHIP* Reviews



GOING FORWARD IN 2022

- Update *NC SHIP* Community Council Composition
- Identify NC DHHS leads for each indicator
- Build cross-sectoral agency partners for each *HNC 2030* indicator with the help of NC Institute of Medicine (NCIOM)
- Engage, nominate, and recruit community organizers, advocates, and activists
- Add a digital platform for public engagement





STATE HEALTH IMPROVEMENT PLAN

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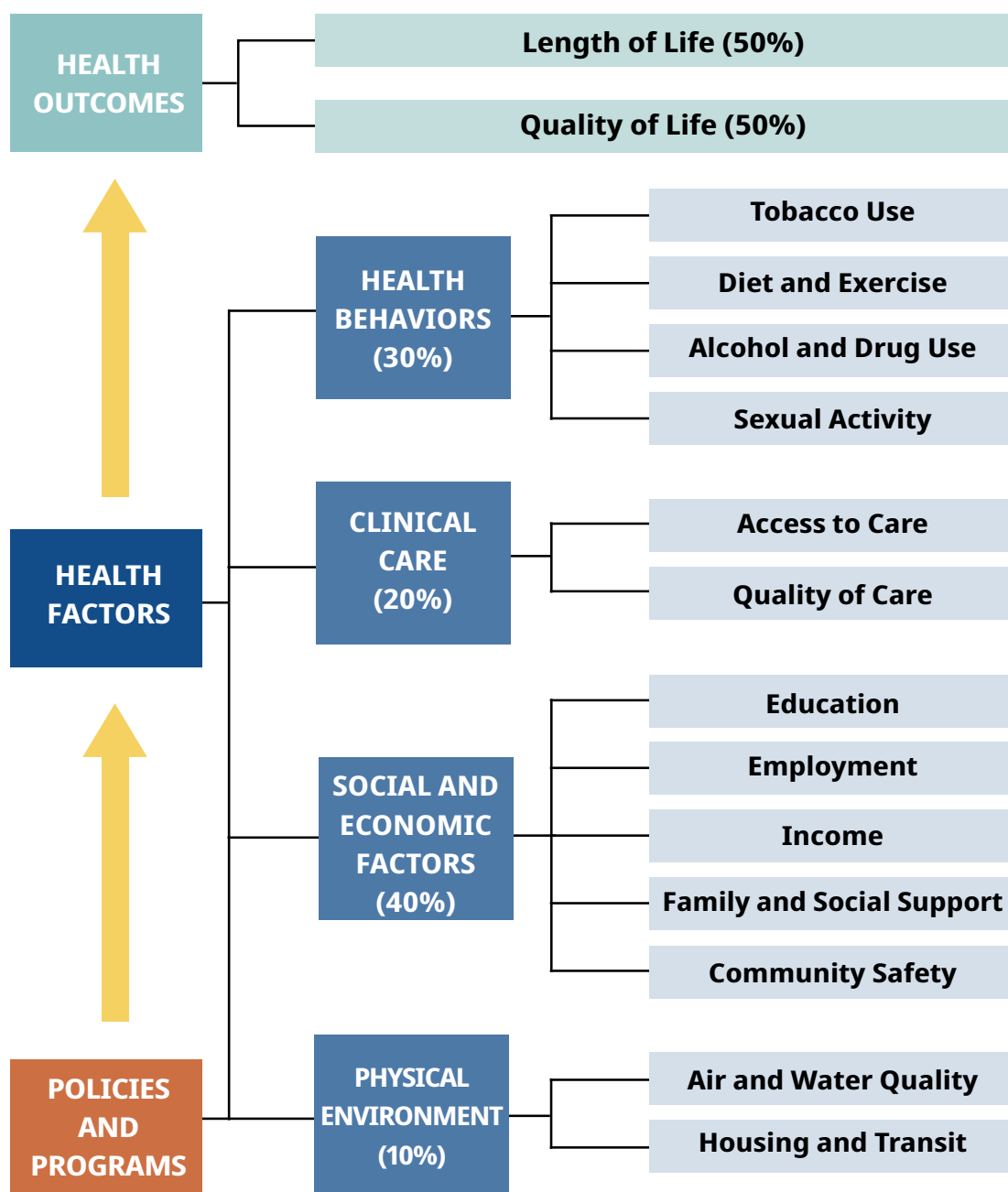
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POPULATION HEALTH MODEL

The *NC SHIP* adopted the Robert Wood Johnson Foundation population health framework that was developed by the University of Wisconsin. The framework is sometimes referred to as the County Health Rankings Model (Figure 1). Healthy People 2030 also uses the same framework for organizing its work at the federal level.

Health begins in families and communities and is largely determined by the social and economic factors (40%) in which we grow up, live, work, and age. Factors such as health behaviors (30%) and our physical environment (10%) are well known to impact health (Glanz, Rimer, & Viswanath, 2015). Factors related to clinical care (20%) are also responsible for quality of life and life expectancy. Together, these factors are called *drivers of health* and they directly affect health outcomes like development of disease and life expectancy.

Figure 1. The County Health Rankings Model *Used with permission of the University of Wisconsin Population Health Institute (2018)*



RESULTS-BASED ACCOUNTABILITY FRAMEWORK

Results-Based Accountability (RBA) is a disciplined way of thinking and acting to improve entrenched and complex social problems – sometimes referred to as *wicked problems*. Communities use it to improve the lives of children, youth, families, and adults. RBA is also used by organizations to improve the effectiveness of their programs.

HNC 2030 and the *NC SHIP* adopted RBA methodology for community dialogue based on plain language that anyone can understand. Governmental agencies are known for their use of jargon, and public health is no exception. By adopting RBA, public health sends the message that we must have a common language for talking about *wicked problems* – a language that community members can understand.

RBA teaches us to care more about going in the right direction rather than setting unrealistic goals. We embrace “Turn the Curve Thinking” to make decisions about what to do, and then use “turn the curve thinking” to see if what we do is working. RBA teaches that there are two types of accountabilities: population accountability and performance accountability. We reject the suggestion that holding any one agency/organization, or even multiple organizations accountable for solving *wicked problems* at the population level is helpful. However, being accountable for the performance of programs, policies, and practices is our direct responsibility. Mark Friedman, the originator of RBA, says that too many people associate accountability with punishment. When applied correctly, RBA will help us to:

- Know if what we do is working
- Explore how we can achieve measurable results faster, and
- Communicate why the work we do matters to those we serve and those that fund our work.

RBA uses data and disciplined thinking to tell a story in plain language. RBA replaces S.M.A.R.T. goals and objectives with three simple measures:

- How much did you do?
- How well did you do it?
- Is anybody better off?

NC DHHS, DPH and our cross-sectoral stakeholders are motivated to do the right things and do them well so that we and our partners can make a difference in the lives of the people we serve. We set targets for the *HNC 2030* indicators, but *any* improvement in the right direction for these indicators defines our success.

CLEAR IMPACT SCORECARD

Clear Impact Scorecard is a performance management and reporting software for non-profit and government agencies that is used to explain the impact of their work efficiently and effectively, on a web-based platform. The scorecard mirrors RBA and links results with indicators and programs with performance measures.

Figure 2. Clear Impact Scorecard Icons that Align with Results-Based Accountability

	COMMUNITY HEALTH ASSESSMENT / COMMUNITY HEALTH NEEDS ASSESSMENT
	RESULT
	INDICATOR
	PROGRAM / POLICY / PRACTICE
	PERFORMANCE MEASURE

North Carolina Public Health partners with the Foundation for Health Leadership & Innovation (FHLI) to introduce a web-based tool, Clear Impact Scorecard, to track the direction of *HNC 2030* population indicators and program performance measures. In 2021, the tool was introduced statewide. Scorecard tracks the performance measures identified in the community health assessments of local health departments and the Eastern Band of Cherokee Indians (EBCI). These priorities are aligned with the *HNC 2030* population indicators and revised annually when new data become available.

Tracking and reporting data for the 21 *HNC 2030* indicators proved to be a challenge in 2021. The global pandemic and its impact on the United States Census, delayed reporting for seven of the 21 indicators. The NC State Health Improvement Scorecard can be viewed at <https://app.resultsscorecard.com/Scorecard/Embed/75778>.

RESULTS-BASED ACCOUNTABILITY VERSUS S.M.A.R.T. GOALS

The term S.M.A.R.T. goal, often associated with objectives, helps to make sure that objectives are clearly defined and attainable. The goal must be stated in such a way as to be specific, measurable, achievable, relevant, and time-bound. S.M.A.R.T. goals are not useful for tracking population level data because of the competing characteristics of achievable and time bound. S.M.A.R.T. goals are better suited for tracking performance measures within a defined program with some control over the resources needed to improve outcomes.

RBA makes a clear distinction between population accountability and performance accountability (Figure 3).

RBA eliminates the jargon and uses plain language to report:

- How much did you do?
- How well did you do it?
- Is anybody better off?

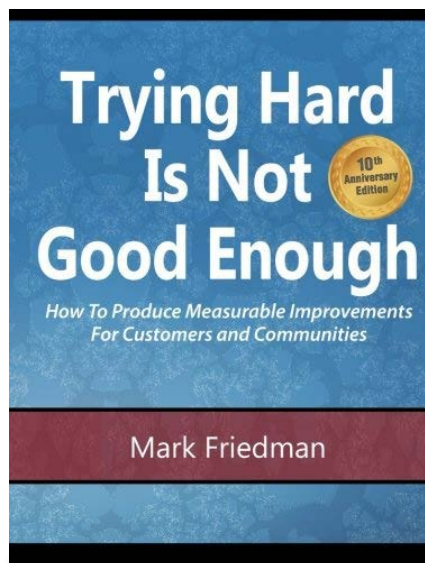


Image 1. *Trying Hard is Not Good Enough: How to Produce Measurable Improvements for Customers and Communities* (Mark Friedman).

Figure 3. Results-Based Accountability

Population Accountability vs Performance Accountability



Population Accountability

The well-being of **Whole Populations**
Communities, Cities, Counties, States,
Nations, World

Performance Accountability

The well-being of **Client Populations**
Governments, Agencies,
Organizations, Programs, Units

OVERVIEW

The *NC SHIP* extends the work of *HNC 2030: A Path Toward Health*. The plan represents the collaborative effort of the NC DHHS, DPH and NCIOM to develop a decennial plan to improve the lives of people who live in North Carolina.

The 2020 *NC SHIP* was developed by DPH in partnership with NCIOM. Together, they solicited stakeholder input from community organizers, civic and faith-based organizations, hospitals and health care systems, health care providers, health consumers, businesses, public and private insurers, public health professionals, education, law enforcement, and social service agencies. The 2022 *NC SHIP* grew out of the annual review of the 2020 *NC SHIP* at the *NC SHIP* Community Council meeting on July 29, 2021, and the subsequent nine Community and Stakeholder Symposia August – September 2021.

The *NC SHIP* consists of five phases (Figure 4).

Figure 4. Five phases of the *NC SHIP*

Phase 1:	Development	Jan 2020 - Nov 2020
Phase 2:	Implementation	Dec 2020 - July 2022
Phase 3:	Strategic Planning	July 2022 - July 2029 (quarterly)
Phase 4:	Monitoring	July 2022 - July 2029 (quarterly)
Phase 5:	Evaluation	July 2029 - Nov 2029 (final)

The *NC SHIP* is based upon the population health framework and uses RBA to monitor trends in 21 population health indicators from *HNC 2030*. The *NC SHIP* Community Council workgroups convene annually in July to prioritize policy changes and identify a team of lead agencies and advocates for each indicator.

Specific programs and practices with a high potential for success are listed in the *NC SHIP*. Responsibility for implementing specific programs and practices lies with the state and local health departments and cross-sectoral partners. North Carolina uses a web-based tool for linking local initiatives to the *NC SHIP*. During the decade 2020-2030, progress toward meeting the *HNC 2030* targets will be continuously monitored using a Clear Impact Scorecard. Maximum transparency is achieved by giving the public full access to the Scorecard as it is continuously updated. (<https://app.resultsscorecard.com/Scorecard/Embed/75778>)

TIMELINE

Development Phase

January 2020 – November 2020

HNC 2030 summarizes how the population level indicators were selected as priorities for the *NC SHIP*. The 21 population indicators represent four categories of factors that affect health, plus two health outcomes (Figure 5).

Figure 5. *HNC 2030* indicators categorized according to a population health framework (Health Factors/Health Outcomes)

HEALTH FACTORS (19)

- Social and Economic Factors (6)
 - Poverty
 - Unemployment
 - Short-term Suspension
 - Incarceration Rate
 - Adverse Childhood Experiences
 - Third Grade Reading Proficiency
- Physical Environment Factors (3)
 - Access to Exercise Opportunities
 - Limited Access to Healthy Food
 - Severe Housing Problems
- Health Behaviors (6)
 - Drug Overdose Deaths
 - Tobacco Use
 - Excessive Drinking
 - Sugar-Sweetened Beverage Consumption
 - HIV Diagnosis Rate
 - Teen Birth Rate
- Clinical Care Factors (4)
 - Uninsured
 - Primary Care Workforce
 - Early Prenatal Care
 - Suicide Rate

HEALTH OUTCOMES (2)

- Infant Mortality
- Life Expectancy

Step 1. In January 2020, NC DHHS, DPH and NCIOM formed a *NC SHIP* Steering Committee to ensure that the planning process was informed by a diverse group of participants. The steering committee representatives included NC DPH staff, NCIOM Project Director and Executive Director, and several members of the *HNC 2030* workgroups.

Step 2. The *NC SHIP* Steering Committee recommended workgroup members with a focus on diversity of race, gender, geographical location, and affiliations.

Step 3. The original planning process included face-to-face work group meetings in March/April 2020. However, the COVID-19 pandemic forced all meetings to be virtual during May/June 2020. Nineteen virtual meetings were held with 135 participants.

Step 4. The *NC SHIP* work group participants identified evidence-based, evidence-informed, and best practices that are working or could work to improve the 21 population health indicators in *HNC 2030*. During the work group meetings, participants were asked to share their knowledge of “what’s working?” and “what could work?” from their diverse perspectives. Work group participants were advised to identify best practices while considering “Turn the Curve Thinking” – a principle associated with RBA (Figure 6).

Step 5. All work group participants received a summary of recommendations in October/November 2020 and were invited to edit the content to reflect the dialogue of the group. The changes were incorporated into the final 2020 *NC SHIP* group.

Figure 6. Characteristics of best practices selected for the *NC SHIP*

WHAT PRACTICES WILL HELP “TURN THE CURVE” ON THE *HNC 2030* INDICATORS?

The types of best practices that we are looking for can be directed at multiple levels:

- Individuals
- Organizations
- Agencies
- Institutions
- Policies

We seek to identify successful practices as evidenced by:

- Lived experience stories from one or more communities/ community members that use the practice
- Studies about the best practices that tell “How much did you do?, How well did you do it?, and is anybody better off?”
- Published research from communities outside/inside NC about use of the practice

The best of the successful practices will appear in the *HNC 2030 Scorecard* and have these characteristics:

- Active, local community engagement
- Focus on health equity/health disparity
- Assessed impact of structural racism
- Claim North Carolina roots
- Successful outcomes over several years
- Widespread community support, and include
- Multilevel interventions

“Nothing for me without me”

Implementation Phase December 2020 – July 2022

Step 1. NC DHHS/DPH published the 2020 *NC SHIP* December 2020.

Step 2. Each participant received a copy of the 2020 *NC SHIP* and was invited to serve on the *NC SHIP* Community Council, July 29, 2021. A total of 132 invitations were extended: 29 participated.

Step 3. Additional participants were invited to the Community & Stakeholder Symposia August – September 2021. The symposia were well attended, with 323 people participating in one or more of the indicator-specific symposia.

Step 4. NC DHHS, NC AHEC, and FHLI built RBA infrastructure and provided 13, low-cost RBA courses to 217 participants using RBA certified faculty (Appendix F).

Step 5. NC DHHS/DPH worked with FHLI and the North Carolina Healthcare Association (NCHA) to introduce health care systems to RBA and Clear Impact Scorecard.

Step 6. NC DHHS/DPH assisted local health departments with the transition from paper-based community health improvement plans to the web-based Clear Impact Scorecard.

Step 7. NC DHHS/DPH and FHLI are working with 85 local health departments and EBCI to align community health improvement plans with one or more *HNC 2030* indicators. At the time of publication an 86th local health department was in formation, with Yancey County separating from the Toe River Health District.

Step 8. NC DHHS/DPH continues to partner with NC AHEC and FHLI to convene learning collaboratives for stakeholders addressing the *HNC 2030* indicators.

Step 9. NC DHHS/DPH updated the 2020 *NC SHIP* and published the 2022 *NC SHIP* in July 2022.

Next steps:

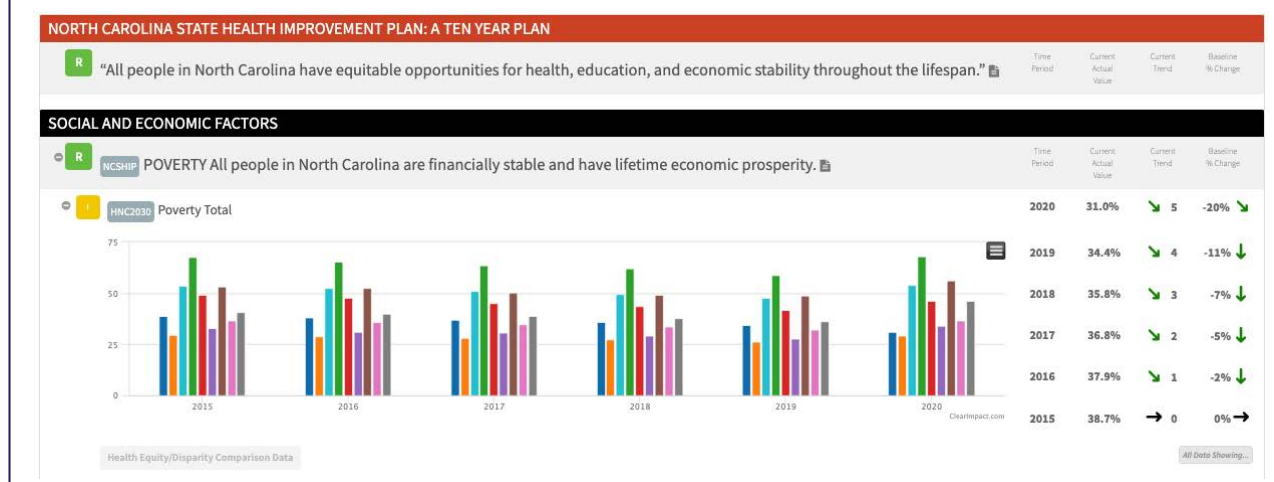
- Identify a DHHS Engagement Coordinator.
- Identify *HNC 2030* Indicator Co-Leaders from DHHS.
- Identify *HNC 2030* Indicator Co-Leaders from Community Representatives.
- Schedule the July 2022 *NC SHIP* Community Council and Indicator Work Group sessions.

Strategic Planning July 2022 - July 2029 (quarterly)

Next steps:

- Intentionally recruit community representatives (organizers, leaders, and activists) to achieve a 1:1 ratio of agency/ institutional affiliation members to community representatives on the *NC SHIP* Community Council.
- Convene the 2022 *NC SHIP* Community Council Meeting and Indicator Work Group Sessions.
- Prioritize indicators and policies.
- Assign advocates for all prioritized policies.
- Document strategies for adopting/revising policies in Clear Impact Scorecard quarterly.

Figure 7. Snapshot of a HNC 2030 Scorecard: Social and Economic Factors



Monitoring Progress

July 2022 - July 2029 (quarterly)

Next steps:

- Monitor progress for all *HNC 2030* indicators at the population level and performance level and update Clear Impact Scorecard quarterly.
- Revise (July – December) and publish (January) the *NC SHIP*.

Evaluation

July 2029 - November 2029 (final)

LEARNING COLLABORATIVES

A learning collaborative brings people with similar interests together to study and apply quality improvement methodology to a focused topic area. NC DPH and NC AHEC started learning collaboratives around each of the *HNC 2030* indicators beginning in Winter 2021. The learning collaboratives support the adoption of best practices in the community that contribute to improved population health outcomes. The learning collaboratives are anchored in RBA, a permanent continuing education curriculum available through NC AHEC. Initial learning collaboratives will be organized around the NC AHEC RBA trainings (Figure 8). The concept is that people are trained to "Do the Right Things" in RBA and then draw upon their peers, partners, stakeholders, and community members to learn how to "Do Them Well."

PUBLIC COMMENT AND REVIEW

The 2020 *NC SHIP*, 2022 *NC SHIP*, and the Clear Impact *HNC 2030* and *NC SHIP* Scorecards are available on the NC DPH website: <https://schs.dph.ncdhhs.gov/units/ldas/hnc.htm>. Public comments are welcome and may be submitted by contacting the Director of Community Health Assessment using the posted contact information. All public comments are reviewed and shared with the *NC SHIP* Community Council at the annual meeting. The continuous review process allows NC DPH to consider changes to the *NC SHIP* when indicated.

Figure 8. NC AHEC 2021-2022 dates for RBA training

Results-Based Accountability: Do the Right Things and Do Them Well	
• November 30 - December 2, 2021: Eastern AHEC	• April 12-14: South East AHEC
• January 11-13: Area L AHEC	• May 3-5: Mountain AHEC
• February 15-17: Charlotte AHEC	• May 24-25: Northwest AHEC
• March 1-3: Southern Regional AHEC	• June 7-9: Greensboro AHEC

ROLE OF NC DHHS AND PARTNERS

- NC Division of Public Health is responsible for conducting a state health assessment (SHA) every five years. At the beginning of each decade, NC DPH partners with a larger group of stakeholders to set decennial objectives. In 2019-20, NC DPH partnered with NCIOM to produce its *2019 SHA/HNC 2030* report. NC DPH also produces a state health improvement plan based upon the *SHA (2020 NC SHIP)*.
- NC DPH is responsible for creating and maintaining the state level *HNC 2030* Scorecard. This includes training and technical assistance to local health departments and their partners in linking local scorecards to the state scorecard.
- NC DPH is responsible for convening annual meetings of the *NC SHIP* Community Council. NC DPH ensures that all Council members receive annual orientation in the use of Scorecard to monitor progress on the *HNC 2030* indicators (**Figure 9**).
- NC DPH and partners are responsible for promoting and supporting levers for change. Levers for change and partners are captured for each *HNC 2030* indicator. They are found under “What Works” and “Partners Who Can Help Us” in the *NC SHIP*.

ROLE OF LOCAL HEALTH DEPARTMENTS AND MULTI-SECTOR PARTNERS

- Local health departments and partners contribute to the state plan by implementing best practice programs, timely interventions, and promising new activities to address complex social, economic, educational, environmental, and health needs. Performance accountability is transparent and captured in local Scorecards that can be linked to the state level *HNC 2030* Scorecard.
- Local health departments are responsible for ensuring that staff are trained in RBA.

NC SHIP COMMUNITY COUNCIL

- The *NC SHIP* Community Council provides oversight on “Turn the Curve Thinking” for the 21 *HNC 2030* indicators (**Figure 5**). Initially, the composition of the *NC SHIP* Community Council consisted of individuals who participated in the *HNC 2030* and/or *NC SHIP* working groups. Beginning in 2022, NC DHHS will designate leads for each indicator and work with NCIOM to build cross-sectoral agency partners. NC DHHS leads and cross-sectoral agency partners will prioritize and pursue those policies with the most support.
- The *NC SHIP* Community Council meets annually to review progress on the *NC SHIP* and provides ongoing recommendations to achieve results that improve population health.
- NC DPH convenes the *NC SHIP* Community Council meeting and provides staff support for its annual report.

Figure 9. Roles and responsibilities of state and local health departments and their partners in the *NC SHIP*



STRATEGIES TO ACHIEVE RESULTS

After careful consideration about what works and what has not been working over the last 20 years, NC DPH and its partners identified six strategies to achieve the result of a transparent, data-driven reporting system for community health improvement. These strategies are consistent with the values of NC DHHS/DPH, FHLI, and NC AHEC.

STRATEGY 1

Use data to improve accountability for community health improvement.

STRATEGY 2

Implement RBA/Clear Impact Scorecard statewide on a voluntary basis.

- Build on the positive experience with 16 counties and hospitals in western North Carolina.

STRATEGY 3

Fund statewide expansion of RBA/Clear Impact Scorecard at no cost to participating counties/hospitals using grant funds from The Duke Endowment.

- Reduce barriers to adoption of technology/changes to existing processes.

STRATEGY 4

Develop a collaborative infrastructure for communication, monitoring, training, technical assistance, and coaching.

- A multisectoral approach brings additional resources when expanding a simple review & approval process to a continuous quality improvement process.

STRATEGY 5

Continue research identifying factors associated with accountability of community health improvement.

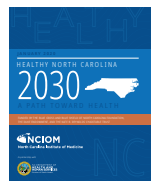
- Multiple factors likely affect accountability.
- RBA and Clear Impact Scorecard address transparency, data-driven, and disciplined thinking.

STRATEGY 6

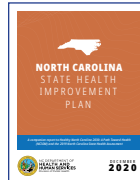
Continue research that examines return on investment and cost savings to local health departments and their partners.

- Sustainability is key to permanence: If state and community health assessment and health improvement are core governmental public health functions, then the core infrastructure should be publicly funded.
- When businesses benefit directly from the work, they are more likely to contribute to the cost of sustaining the work.

Figure 10. Major milestones in the NC State Health Improvement Plan



HEALTHY NORTH CAROLINA 2030 JANUARY 2020



NC STATE HEALTH IMPROVEMENT PLAN DECEMBER 2020

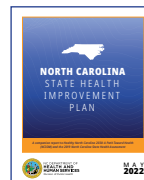


- *HNC 2030* Scorecard built and shared
- *NC SHIP* Community Council Meeting - July 29, 2021
- NC Community Stakeholder Symposia - August through September 2021
- Built RBA Infrastructure with NC AHEC and FHLI
- Worked with 85 local health departments to align Community Health Improvement Plans with one or more *HNC 2030* Indicators

NEXT STEPS

APRIL - DECEMBER 2022

- Select *HNC 2030* Indicator Co-Leads
- Convene *NC SHIP* Community Council
- Select Top Policy Priorities
- Form Strategy Workgroups
- Update Scorecard Data
- Prepare 2023 *NC SHIP*



STATE HEALTH IMPROVEMENT PLAN 2022



- Built *NC SHIP* Scorecard with assigned tasks
- Opened *HNC 2030* Resource Center
- Presentations/collaborations with multiple partners

Table 1 provides a summary of policy initiatives proposed for consideration by diverse community stakeholders during the annual review of *HNC 2030* indicators and does not constitute an endorsement by NC DHHS/DPH. Many of the proposed policies were originally suggested in *HNC 2030: A Path Toward Health*, and others were voiced by the *NC SHIP* Community Council members and community stakeholders July-September 2021 (pp. 8-9). Some of the policies are also those included in the Robert Wood Johnson Foundation County Health Rankings & Roadmaps Evidence Library of “What Works for Health” - <https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health>. NC DHHS/DPH welcomes the opportunity to work with its partners and the community to prioritize the proposed policy initiatives that have the greatest potential for “Turning the Curve” on the *HNC 2030* indicators.

Table 1. Proposed policy initiatives in the 2022 NC SHIP

INDICATOR 1: POVERTY

- Create and expand legislation and advocate with employers to provide paid family medical leave, earned paid sick leave, kin care, and safe days for all caregivers
- Ease negative impact of “benefits cliffs” caused by reductions in benefits, by increasing phase-out periods
- Eliminate taxation on sanitary products including menstrual supplies, diapers, and breastfeeding supplies
- Expand Medicaid eligibility
- Expand the availability and amount of childcare subsidies to reflect the cost of care more adequately
- Raise the minimum wage to \$15.00 per hour
- Restore the North Carolina Earned Income Tax Credit
- Support “early college while in high school” programs, such as REaCH and SEaRCH

INDICATOR 2: UNEMPLOYMENT

- Create and expand legislation and advocate with employers to provide paid family medical leave, earned paid sick leave, kin care, and safe days for all caregivers
- Expand access to higher educational opportunities
- Expand transit options in rural and low-income communities
- Improve access to personal finance credit scores
- Increase access to affordable childcare
- Increase access to broadband Internet
- Pass fair chance hiring policies for county and local employees, and work with employers to pass fair chance hiring policies for themselves
- Seek a national health insurance / national service program, e.g., An Economic Bill of Rights for the 21st Century
- Shift funding from industrial recruitment to support of small businesses and social enterprises
- Support people with disabilities and those in recovery to live their lives as fully included members of the community by implementing key employment initiatives like Competitive Integrated Employment and Employment First

INDICATOR 3: SHORT-TERM SUSPENSIONS

- Develop statewide system of restorative justice programs
- Disrupt the school-to-prison pipeline, beginning with preschool, by reducing the use of school suspensions and expulsions and increasing the use of counseling services
- Implement trainings and policies for trauma-informed schools
- Include suspension rate in measures of school quality
- Increase racial, ethnic, gender, and disability status diversity among school and childcare leadership and staff and the institutions that train them
- Support systemwide training throughout the education system to raise awareness of implicit bias

INDICATOR 4: INCARCERATION RATE

- Ensure access to behavioral health treatment, adequate medical care, and stable housing for those returning from incarceration
- Expand existing or create community Medication Assisted Treatment programs for people with substance use disorder detained in correctional facilities
- Implement standardized, evidence-based programs to reduce recidivism
- Improve access to treatment for substance use disorders, physical illnesses, and mental illnesses
- Improve conditions in jails and prisons to reduce harmful impact of incarceration and foster successful reintegration into the community
- Improve educational outcomes, particularly for young men and boys of color
- Increase access to multi-systemic therapy for juvenile offenders
- Invest in public health alternatives to traditional law enforcement and sentencing, particularly for behavioral health issues
- Reduce intergenerational and neighborhood poverty
- Secure funding to develop policies and practices that enhance the courts’ capacity to respond to victims and others who have experienced trauma

INDICATOR 5: ADVERSE CHILDHOOD EXPERIENCES

- Expand community and domestic violence prevention programs
- Increase access to behavioral health treatment
- Increase access to children’s mental health services by expanding mental health services in primary care, schools, and specialty care
- Increase access to evidence-based parenting (including fatherhood programs), early intervention, and home visiting programs
- Increase minimum wage and employment opportunities
- Invest in better data to enhance ability to assess and address adverse childhood experiences
- Invest in care management and connections to treatment for families with substance use disorders who are involved in the Child Welfare System
- Strengthen Juvenile Crime Prevention Councils

INDICATOR 6: THIRD GRADE READING PROFICIENCY

- Expand community and domestic violence prevention programs
- Expand statewide access to NC Pre-K, 4-, and 5-star early learning programs and other high-quality early childhood programs
- Fund statewide multisector community collaboration efforts to include children from low-income families and people of color
- Implement attendance interventions for chronically absent students
- Increase access to evidence-based parenting (including fatherhood programs), early intervention, and home visiting programs
- Increase funding and reach of Reach Out and Read programs
- Increase funding to public schools and early learning programs that serve those children with the highest barriers to success, including children from low-income families and people of color
- Invest in better data to readily identify households facing barriers to early childhood learning
- Reinforce the talent pipeline for early educators for children from birth through third grade by increasing compensation through dedicated funding, ensuring pay parity, and sustaining investments in training and professional development
- Strengthen Juvenile Crime Prevention Councils

INDICATOR 7: ACCESS TO EXERCISE OPPORTUNITIES

- Adopt “Complete Streets” policies based on NC Department of Transportation guidelines
- Design “First and Last Mile Connections” and ADA-complaint shelters to support safe access to public transportation
- Expand transit services to increase access to places for physical activity
- Increase number of accessible community parks, particularly in rural areas
- Increase number of biking trails and lanes, walking trails, and greenways
- Increase the number of joint use/open use policy agreements for school playground facilities
- Increase opportunity for exercise for school children including active recess, physically active classrooms, school-based physical education enhancements, Walking School Buses, Safe Routes to School
- Maintain safe and well-lit sidewalks
- Promote mixed use development
- Provide public access to municipal recreation facilities
- Rethink prioritization measures for improvements, such as crash data, identification of marginalized populations, and infrastructure needs for vulnerable communities

INDICATOR 8: LIMITED ACCESS TO HEALTHY FOOD

- Continue, expand, and institutionalize the Supplemental Nutrition Assistance Program (SNAP) online purchasing pilot
- Enhance how children and families access programs supporting their well-being, including SNAP, WIC, CACFP, Medicaid, NCCARE360 through better data and analysis, infrastructure, and integration
- Establish a public-private fund for stimulating the development/renovation/expansion of new and existing community-supported venues
- Expand transit options in rural and low-income communities
- Implement competitive pricing for healthy foods
- Implement healthy food procurement and food served policies in public and private organizations and businesses
- Implement school breakfast programs and school fruit and vegetable gardens
- Include healthy foods in convenience stores and food pantries
- Provide additional funding and support to School Nutrition Programs to expand healthy, locally sourced food options and reduce financial barriers for students
- Provide financial incentives such as “Double Up Food Bucks” for SNAP/FNS recipients for purchasing fresh fruit and vegetables from grocery stores and farmers markets
- Support equitable, food-oriented development that drives economic growth in low-income and historically marginalized communities
- Support farmers’ efforts to maintain active crop production in areas with high land prices
- Support farmers’ markets and enable Electronic Benefit Transfer payment at farmers’ markets
- Support regional food hubs in adopting solid business models, with built-in reliance on subject matter experts

INDICATOR 9: SEVERE HOUSING PROBLEMS

- Consider regulatory change allowing mobile homes to be registered as real property (homes), not as personal property (vehicles)
- Enforce fair housing laws and create affordable housing legislation
- Expand housing support services that implement a housing first model and accept people with substance use disorders or persistent mental illness
- Expand rapid re-housing programs to transition families and individuals experiencing homelessness into permanent housing quickly, often with supports such as short-term financial assistance, case management, landlord negotiations, etc
- Implement “right to counsel” measures to provide tenants with access to legal representation when facing landlords in court
- Institute community land trusts in which the community purchases the land a home is on to lease to homeowners with low and middle incomes and require homeowners to sell the home back to the trust or to another resident with low income upon moving
- Promote the Weatherization Assistance Program and Low-Income Home Energy Assistance Programs to help low income families meet their energy needs
- Support people with disabilities to live their lives as fully included members of the community by engaging in an inclusive process to develop and implement an updated strategic Olmstead plan
- Support programs designed to increase home ownership for people of color
- Update housing standards for agriculture workplace housing (H2A housing), as regulated by the federal Occupational Safety and Health Administration
- Update the Migrant Housing Act of North Carolina to promote safe and healthy home environments for migrant workers

INDICATOR 10: DRUG OVERDOSE DEATHS

- Advocate for comprehensive resource repositories, such as 211 or NCCARE360
- Encourage insurance companies to expand access to treatment and recovery services by piloting alternative pain management models
- Expand housing support services that implement a housing first model and accept people with substance use disorders
- Expand Medicaid eligibility
- Expand peer support specialist programs
- Expand rapid access to crisis services, including implementing the national 988 number*
- Implement broader use of NC Controlled Substance Reporting System by health care providers and pharmacies
- Implement "Formerly Incarcerated Transition" programs
- Improve access to drug treatment programs, including medication-assisted treatment
- Increase access to care for justice-involved populations who have behavioral health needs by diverting more people away from incarceration and into treatment, adding more jail-based "medication assisted treatment" programs, and restoring individuals' capacity in jail- and community-based settings
- Increase distribution of naloxone
- Increase the use of agonist therapies (methadone and buprenorphine)
- Increase training for county commissioners on evidence-based practices for substance use disorder
- Increase training for health care providers on buprenorphine prescribing
- Increase training for health care providers on safe prescribing practices
- Invest in care management and connections to treatment for families with substance use disorders who are involved with the Child Welfare System
- Invest in long-term support for syringe service programs, and expand their ability to increase drug checking to prevent overdoses from contamination
- Support policies that decriminalize and promote treatment of substance use disorder
- Support the cost of treatment, safe recovery housing, and prescriptions

**DHHS Press Release dated 4/27/22: NC Awarded Grant to Transition to 9-8-8 Suicide Prevention Lifeline Number This Summer. <https://www.ncdhhs.gov/news/press-releases/2022/04/27/nc-awarded-grant-transition-9-8-8-suicide-prevention-lifeline-number-summer>*

INDICATOR 11: TOBACCO USE

- Eliminate cigarettes from pharmacies
- Eliminate sale of loose cigars and cigarettes
- Enforce regulations that prohibit licensed tobacco retailers from selling tobacco products to underage buyers
- Enforce smoke-free multi-unit, public housing
- Expand Medicaid eligibility to include coverage for tobacco cessation treatment
- Fund comprehensive state tobacco control programs to levels recommended by Centers for Disease Control and Prevention (CDC)
- Implement state and local tobacco-free and smoke-free air policies that include electronic cigarettes
- Increase access to treatment based on the N.C. Tobacco Treatment Standard of Care, to include counseling and FDA-approved medications
- Increase number of paid staff at the state/local level to conduct comprehensive tobacco control programs
- Increase the number of tobacco-free public parks
- Increase the price of tobacco products by raising the current state tax on tobacco products
- Provide nicotine replacement options and services to the uninsured and underinsured
- Raise state minimum sales age from 18 to 21 and establish permitting of tobacco retailers
- Recommend an electronic cigarette policy for restaurants and bars
- Remove state preemption of local government regulations on the sale, promotion, distribution, and display of tobacco products
- Restrict the sales of flavored tobacco products
- Revise zoning ordinances to control placement of shops that sell tobacco, limiting the number of these shops per area and ensuring they are placed a safe distance from children's areas
- Support Tobacco Treatment Specialist Training for historically marginalized communities

INDICATOR 12: EXCESSIVE DRINKING

- Consider local ordinances related to the sale and consumption of alcohol at local events
- Enforce state laws restricting beer and wine couponing
- Expand Medicaid eligibility
- Hold alcohol retailers liable for intoxicated or underage customers who cause injury to others
- Increase alcohol excise taxes
- Increase funding for compliance audits
- Increase number and access to programs
- Integrate the process of Screening, Brief Intervention, and Referral to Treatment into medical settings
- Reduce density of alcohol retailer establishments
- Reduce the days and hours of alcohol sales
- Support and maintain state-controlled alcohol sales

INDICATOR 13: SUGAR-SWEETENED BEVERAGE CONSUMPTION

- Establish healthy food procurement policies that support public and private investment in healthy food, and increase availability of healthy alternatives to sugary drinks
- Implement a sugar-sweetened beverages (SSBs) tax with revenues to address equity issues
- Integrate “Rethink Your Drink” DCD and SNAP-Ed toolkit into school curricula, promoting water as healthy alternative to sweetened beverages
- Limit “default beverage” options for children’s meals in restaurant and educational settings to include only milk, 100% fruit juice, or water
- Recommend NC Department of Public Instruction (DPI) adopt a statewide policy permitting students to bring water bottles to school (containing only water)
- Work with clinicians, medical practices, and insurance providers to add SSB screening questions to patients’ electronic health records

INDICATOR 14: HIV DIAGNOSIS

- Address systemic issues of provider discomfort with discussions about sexual health, including HIV by providing continuing professional development through NC AHEC and expansion of medical school curriculum
- Allow pharmacists to dispense post-exposure prophylaxis regimens
- Expand affordable housing programs and increase number of harm-reduction programs, including needle exchange programs
- Expand Medicaid eligibility for HIV-related healthcare
- Expand North Carolina’s provider network for HIV care
- Implement High Impact Prevention (HIP) through coordinated interventions focused on increasing the number of people who are aware of their HIV status and increase access to prevention and treatment.
- Increase access pre-exposure prophylaxis (PrEP) for individuals at high risk for HIV transmission
- Increase education and healthcare access for formerly incarcerated populations
- Increase same day access to a full array of contraceptive options in health care setting

INDICATOR 15: TEEN BIRTHS

- Increase access to educational programs for youth in juvenile justice and foster care to provide education about pregnancy and sexually transmitted infections (STIs)
- Increase payer coverage of post-partum long-acting contraception
- Increase same day access to a full array of contraceptive options in health care settings
- Make contraceptives available in educational facilities
- Require that sex education curricula contain medically accurate information
- Review school sex education policies to ensure they contain information on avoiding teen pregnancy and sexually transmitted infections

INDICATOR 16: UNINSURED

- Determine need for more community health clinics by employing data analysts
- Expand community health workers to empower communities to ensure all individuals can access healthcare
- Expand Medicaid eligibility criteria
- Increase publicity and navigator funding to provide instruction and access for open enrollment
- Increase the number of bilingual healthcare and insurance providers and staff
- Leverage community benefit dollars from Medicaid Transformation to meet the needs of the uninsured
- Support bans or limitations on short-term health plans

INDICATOR 17: PRIMARY CARE CLINICIANS

- Assess recruitment strategies used by colleges and universities that focus on rural needs
- Develop long-term solutions to healthcare workforce challenges with on increasing the number of North Carolina health care providers from historically marginalized populations
- Ensure highspeed Internet access to support access to telehealth, electronic health records and controlled substance reporting system sites
- Expand Medicaid to support financial viability of primary care providers serving low income patients
- Expand medical school training and learning experiences focused on the skills necessary to practice successfully in rural areas
- Grow NCCARE360 by adding more health systems, payers, providers
- Increase patient access and provide for adequate compensation for consultations with specialists
- Increase requirement for number of rural health clinical rotations for physician assistants (PAs) and Advanced Practice Nurses (APNs)
- Increase telehealth primary care initiatives in rural areas
- Increase the number of residency positions in rural areas
- Invest in rural economies
- Review and optimize middle and high school career and tutoring programs to augment math and science skills
- Support increased funding for provider loan repayment programs that incentivize primary care providers to practice in medically underserved areas
- Support pipeline programs in rural areas to encourage high school and college students to pursue careers in medicine and primary care

INDICATOR 18: EARLY PRENATAL CARE

- Allow certified nurse midwives to practice under their full authority
- Expand Medicaid eligibility
- Expand safe and reliable public transit options
- Provide group prenatal care, childbirth education, and doula services as covered services by Medicaid
- Strengthen workforce diversity and cultural humility in the delivery of prenatal care services
- Use community health workers to provide outreach and education to women of childbearing age in underserved communities
- Utilize the Children's Health Insurance Program option to provide coverage for comprehensive prenatal care to undocumented immigrant women

INDICATOR 19: SUICIDE

- Create safety nets for people that are unemployed or laid off from work
- Create trauma-informed schools with access to mental health providers
- Expand access to telemental health service
- Expand Medicaid eligibility criteria to increase access to mental health services
- Expand rapid access to crisis services, including implementing the national 988 number *
- Implement policies targeted to decrease access to lethal means
- Improve access to maternal mental health services
- Improve access to social services and other supports
- Increase programs that provide mental health services and support for LGBTQ youth
- Increase programs that provide mental health services and support for military veterans
- Increase the use of universal screenings for perinatal mood/anxiety disorder
- Support the integration of physical and mental health

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INDICATOR 20: INFANT MORTALITY

- Adopt national maternal and infant risk-appropriate Levels of Care Standards
- Allow pharmacists to dispense oral and transdermal hormonal contraceptives
- Expand efforts to prevent infant deaths related to unsafe sleep environments
- Improve access to, and use of, prenatal care, including Centering Pregnancy Programs, group prenatal care, evidence-based home visiting programs, and doula services
- Improve pre-conception routine medical check-ups and family planning counseling
- Include cultural and linguistic competency in preconception routine medical checkups and reproductive life planning so all babies see their first birthday
- Increase access to health insurance
- Increase access to smoking cessation, obesity and diabetes prevention, and alcohol use programs to women of reproductive age and to pregnant people
- Increase businesses, faith entities, and public buildings that qualify as breastfeeding friendly, and normalize breastfeeding in public spaces
- Support training on health equity including implicit bias and determinants of health
- Utilize the Children's Health Insurance Program option to provide coverage for comprehensive prenatal care to undocumented immigrant women

INDICATOR 21: LIFE EXPECTANCY

- Assess and increase access to medical and community services for people with Alzheimer's disease and related dementia through improved transportation services, telehealth services, and incentives for new models of care
- Build and expand key metrics, reporting, and dashboards that identify and monitor health disparities in key health outcomes to drive action and provide transparency into health equity initiatives
- Cultivate collaboration between multidisciplinary professionals to reduce falls and fall-related injuries
- Establish and fund a comprehensive, integrated state data infrastructure using a population health model to assure the timely identification, collection, analysis, integration, visualization, and dissemination of data from global, national, state, and local resources
- Foster partnerships to increase awareness of fall risk factors and advance access to fall prevention interventions
- Improve access to free radon test kits, particularly to historically marginalized populations
- Support the North Carolina Housing Finance Agency by increasing grant funds to support the installation of radon mitigation systems among homeowners financially eligible

LOCAL HEALTH DEPARTMENT COMMUNITY PRIORITIES

The state health assessment and improvement plan incorporates local community health and tribal priorities. In addition to 86 local health departments, North Carolina has eight state recognized tribes (the Coharie, the Eastern Band of Cherokee Indians, the Haliwa-Saponi, the Lumbee Tribe of North Carolina, the Meherrin, the Sappony, the Occaneechi Band of the Saponi Nation and the Waccamaw Siouan). The Eastern Band of Cherokee Indians (EBCI) is also a federally recognized tribe. The priorities are aligned with *HNC 2030* population indicators.

North Carolina Public Health partners with FHLI to utilize a web-based tool, Clear Impact Scorecard, to track the direction of *HNC 2030* population indicators and program performance measures. Introduced statewide in 2021, Scorecard tracks the performance measures identified in the community health assessments of local health departments and EBCI (Figures 11,12).

Figure 11. North Carolina local health department community health assessment priorities, 2015-2019

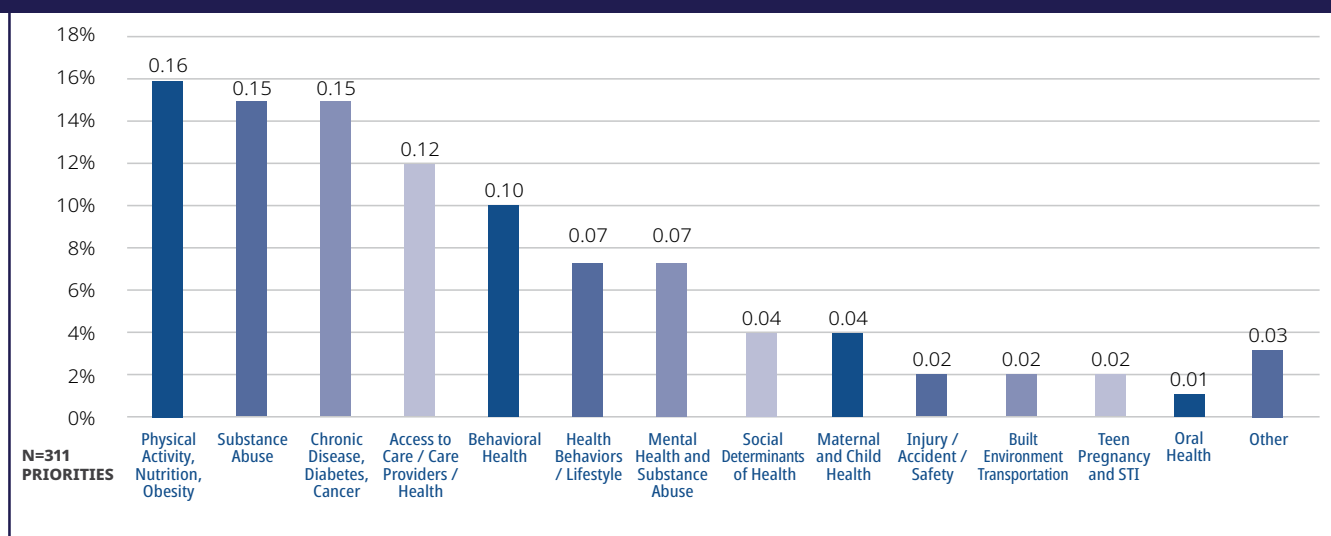
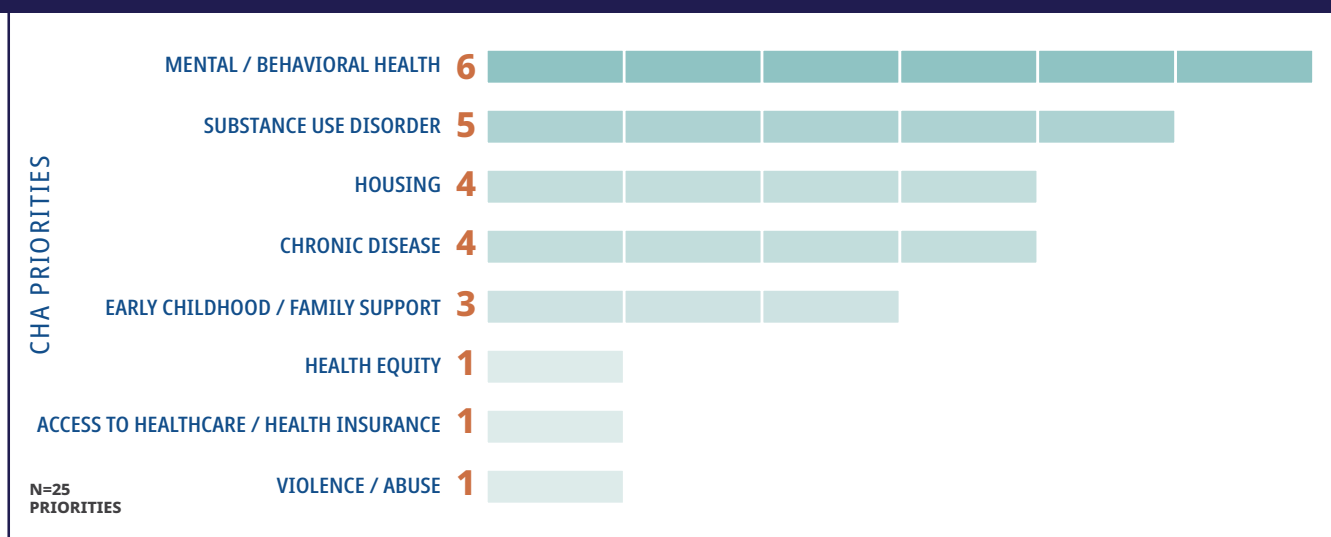


Figure 12. North Carolina local health department community health assessment priorities (CHA), 2020





STATE HEALTH IMPROVEMENT PLAN

SECTION 2

HNC 2030 Indicators



SOCIAL AND ECONOMIC FACTORS

Poverty.....	28-31
Unemployment	32-35
Short-term Suspensions.....	36-39
Incarceration Rate.....	40-43
Adverse Childhood Experiences.....	44-47
Third Grade Reading Proficiency	48-50

WHAT RESULT DO WE WANT?

All people in North Carolina are financially stable and have lifetime economic prosperity.

WHY IS THIS IMPORTANT?

“The current scale of community development is insufficient to address the many complex causes of poverty and to ensure the vital conditions that shape health, wealth, and well-being are met for all Americans. Addressing poverty and meeting the vital conditions are in the direct interest of stakeholders beyond the field of community development, including government officials, businesses and business owners, educators, and healthcare providers and payers. New business models are needed to closely align the financial interests of those who benefit from a healthier, more productive population and those who create the conditions that promote human flourishing.”¹

“The nation’s dominant narrative, which states that people can achieve the American Dream of economic success through resilience and grit and by taking personal responsibility, causes great harm. We have stigmatized poverty with racist and misogynistic language such as “welfare queens and deadbeat dads,” instead of acknowledging our history. This narrative perpetuates White privilege and tells those in stigmatized groups that opportunity is there if they seize it and work twice as hard. Working twice as hard to overcome systemic and structural barriers harms health. Evidence shows how disparities in health outcomes increase with education and income, which contradicts a narrative that emphasizes personal responsibility and hard work.”²

HNC 2030 HEADLINE INDICATOR:
Percent of individuals with incomes at or below 200% of the Federal Poverty Level (FPL)

WHAT DOES THIS INDICATOR MEASURE?

- Reports how many people in the United States are very poor
- Data are from the American Community Survey that is administered by the U.S. Census Bureau annually
- Data are disaggregated by race, gender, county
- Survey data are weighted, thus percentages are estimates

BASLINE DATA FROM HNC 2030

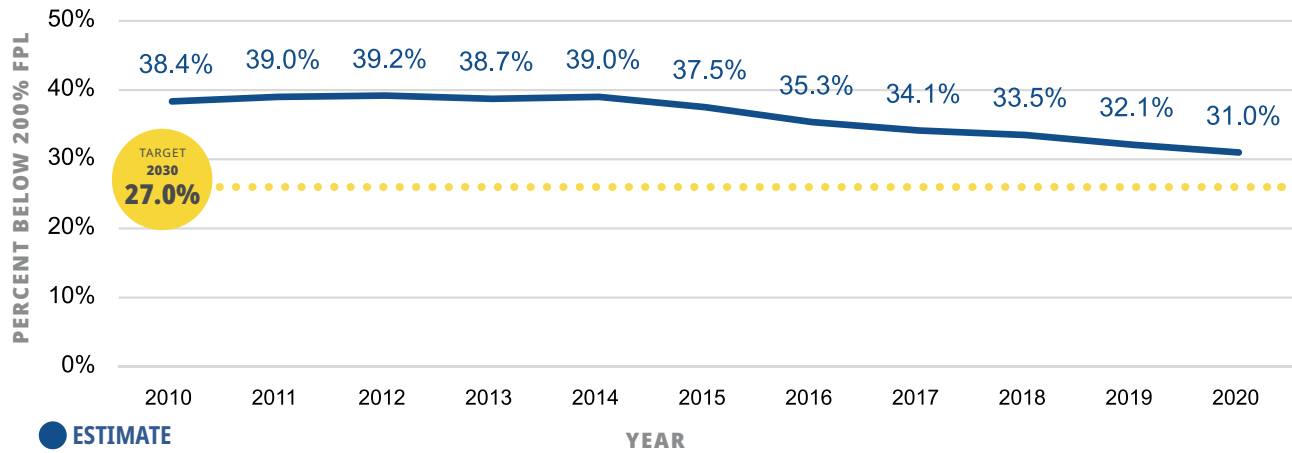


HOW ARE WE DOING?

- The percent of individuals at or below 200% FPL is trending downward for all race/ethnicities since 2012
- The gender poverty gap has increased since 2010 (3.5 percentage points in 2010; 4.2 percentage points in 2020)

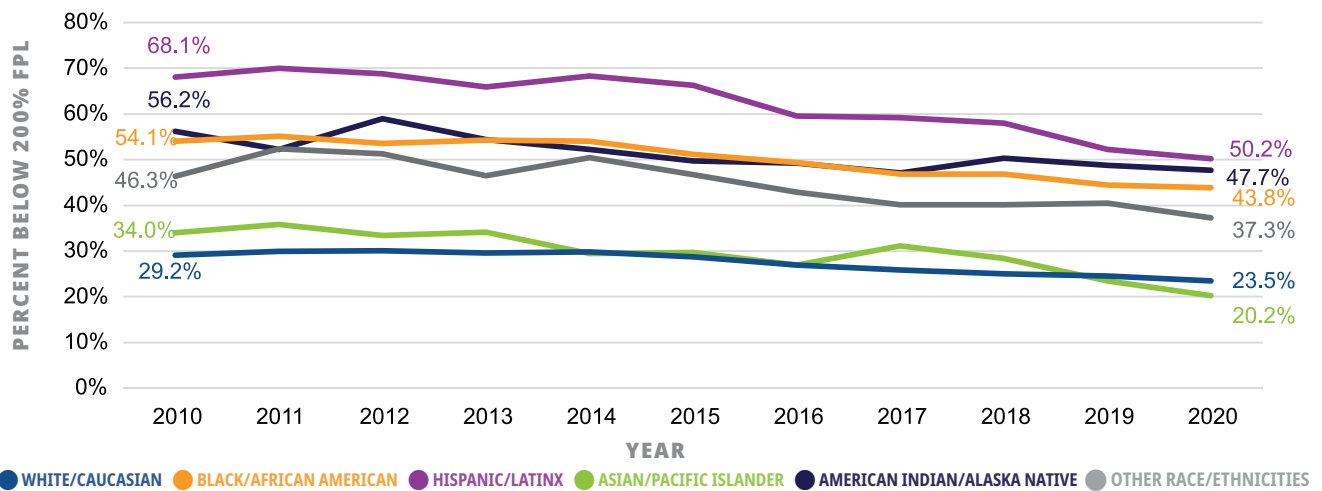
CURRENT DATA TRENDED OVER TIME

Figure 13. Percent of individuals below 200% Federal Poverty Level in North Carolina (2010 - 2020)



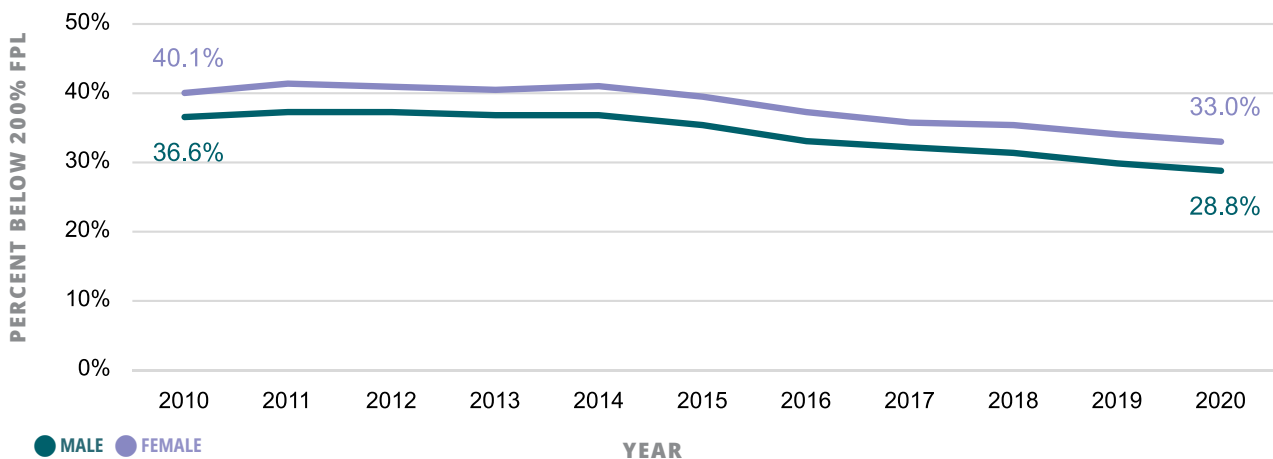
Data source: N.C. State Center for Health Statistics, American Community Survey, 1 year estimates.

Figure 14. Percent of individuals below 200% Federal Poverty Level in North Carolina by race/ethnicity (2010 - 2020)



Data source: N.C. State Center for Health Statistics, American Community Survey, 1 year estimates.

Figure 15. Percent of individuals below 200% Federal Poverty Level in North Carolina by gender (2010 - 2020)



Data source: N.C. State Center for Health Statistics, American Community Survey, 1 year estimates.

THE STORY BEHIND THE CURVE

According to the North Carolina Justice Center, in 2019 the federal poverty guideline was \$25,750 combined income for a family or household of four.

- 1.4 million North Carolinians, or about 1 in every 7 people in the state, lived in poverty ³
- 1 in 5 North Carolinians under 18, or over 430,000 children, lived in poverty ⁴

Higher rates of poverty among women are connected to the lack of support for working parents. ⁶

In 2019, the poverty rate among North Carolina women was more than 20 percent higher than for men.

- 786,000 women, or 14.9 percent, experienced poverty ⁷
- 600,000 men, or 12.2 percent, experienced poverty ⁸

Young children have the highest poverty rate of any age group. ⁹

Many people were close to poverty before the COVID-19 pandemic began. ¹⁰

Due to the impact of the COVID-19 pandemic, the Census Bureau changed the 2020 American Community Survey (ACS) release. Instead of providing the standard 1-year data products, the Census Bureau released experimental estimates from the 1-year data. One should not compare 2020 ACS data to any other data survey years. ¹¹

WHAT OTHER DATA DO WE NEED?

The ACS may be an especially inadequate measure of poverty for 2019 and 2020 because of data lag time of at least a year, and the pandemic impact. Consider:

- Economic Mobility: Job market (income); Savings rate; Ownership (home, business, investment)
- Household Pulse Survey (U.S. Census Bureau). Consider the impact of the pandemic on people's lives: food, housing, and transportation insecurity - <https://www.census.gov/data/experimental-data-products/household-pulse-survey.html>
- Road to Zero Wealth Study - <https://ips-dc.org/report-the-road-to-zero-wealth/>

WHAT COULD WORK TO TURN THE CURVE?

Reparation was perhaps the boldest idea discussed at the 2021 Stakeholder Symposia. Economic reparation is about closing the wealth gap between blacks and whites in the United States.

The attendees in the Stakeholder Symposia talked about the importance of making sure that people with direct lived experience with poverty be involved in the strategies and interventions to combat poverty. With education being a key strategy to end poverty and build wealth, several participants suggested that community colleges encouraged students to work at their own pace – both classroom and online. This practice was seen as helpful to students who did not do well in group settings, classrooms, or rigid environments. Other participants reported that paid apprenticeships helped to finance education and create new paths. Some suggested that teaching entrepreneurship and small business development in high school could give disadvantaged young people greater opportunity.

- Create and expand legislation and advocate with employers to provide paid family medical leave, earned paid sick leave, kin care, and safe days for all caregivers
- Ease negative impact of “benefits cliffs” caused by reductions in benefits, by lengthening phase-out periods
- Eliminate taxation on sanitary products including menstrual supplies, diapers, and breastfeeding supplies
- Expand Medicaid eligibility
- Expand the availability and amount of childcare subsidies to reflect the cost of care more adequately
- Raise the minimum wage to \$15.00 per hour
- Restore the North Carolina Earned Income Tax Credit
- Support “early college while in high school” programs, such as REaCH and SEarCH



**“THE COVID-19 PANDEMIC
REQUIRES A MORAL RESPONSE
THAT TARGETS THE ROOT CAUSES
OF LONGSTANDING POVERTY
AND INEQUITY TO BRING SHARED
PROSPERITY TO ALL NORTH
CAROLINIANS.”**

- Logan Rockefeller Harris, North Carolina
Justice Center (2020)

RECOMMENDED READING/LISTENING

From Here to Equality: Reparations for Black Americans in the Twenty-First Century (2020)
William A. Darity, Jr. and Kristen Mullen (2020)

The ARC of Justice: From Here to Equality (2021)
Duke Sanford School of Public Policy Ways and Means Podcast Series
<https://waysandmeansshow.org/2021/02/24/new-season-arc-justice/>

NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
Child Care Services Association (CCSA)	https://www.childcareservices.org/
Communities in Partnership (CIP)	https://communitiesinpartnership.org/
Cooperative Christian Ministry	https://cooperativeministry.com/
Crisis Assistance Ministry	https://www.crisisassistance.org/
End Poverty Durham	http://endpovertydurham.org/
Equity Before Birth	https://www.equitybeforebirth.com/
GreenLight Fund-Charlotte	https://greenlightfund.org/sites/charlotte/
Latin American Coalition	https://latinamericancoalition.org/
Mary Reynolds Babcock Foundation	https://www.mrbf.org/
NAACP	https://naacp.org/
NCCARE360	https://nccare360.org/
NC Early Childhood Foundation (NCECF)	https://buildthefoundation.org/
North Carolina Community Action Association	https://www.nccaa.net/
North Carolina Early Education Coalition	https://ncearlyeducationcoalition.org/
NC DHHS Office of Economic Opportunity	https://www.ncdhhs.gov/divisions/office-economic-opportunity
North Carolina Justice Center	https://www.ncjustice.org/
NC Coalition Against Domestic Violence	https://nccadv.org/
North Carolina Department of Commerce	https://www.nccommerce.com/
North Carolina Network of Grantmakers (NCNG)	https://ncgrantmakers.org/
North Carolina Poor People's Campaign- A National Call for Moral Revival	https://ppc-nc.org/
Raising Wages NC	https://raisingwagesnc.org/
The Duke Endowment	https://www.dukeendowment.org/program-areas/overview
Z. Smith Reynolds Foundation	https://www.zsr.org/

WHAT RESULT DO WE WANT?

All people of working age in North Carolina have equitable pathways to fulfilling employment throughout life.

WHY IS THIS IMPORTANT?

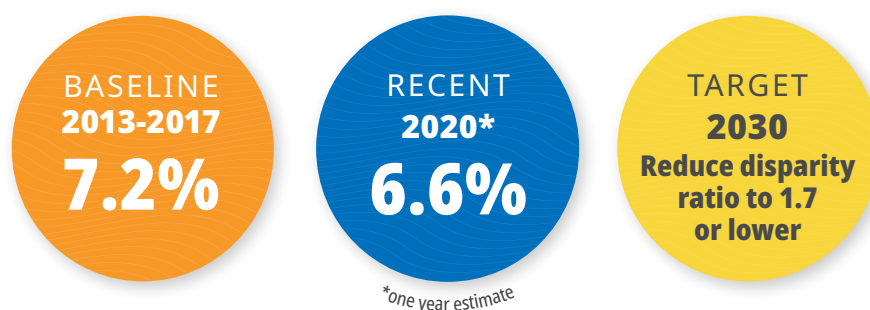
Loss of income is linked to increased vulnerability to disease, unhealthy behaviors, and adverse health outcomes associated with poverty. Unemployment leads to disparities in health insurance coverage limiting access to medical attention and medication.¹

HNC 2030 HEADLINE INDICATOR:
Percent of population aged
16 and older who are
unemployed but seeking work

WHAT DOES THIS INDICATOR MEASURE?

- Data are disaggregated by race, gender, county, poverty level, and age group
- Data are from the American Community Survey
- Measures how many of us, aged 16 and older and looking for work, are unemployed
- Survey is administered annually by the U.S. Census Bureau

BASELINE DATA FROM HNC 2030



HOW ARE WE DOING?

U.S. Census, American Community Survey, one-year estimates show that:

The overall trend in percent of population unemployed but seeking work has declined from 12.6% since 2010 to 4.6% in 2019. However, a 6.4% unemployment ratio (2020) should not be compared to previous years due to provisional 2020 U.S. Census population data. Consensus does support that unemployment increased in 2020 due to multiple pandemic effects.

Trends in unemployment by gender remain consistent 2010-2020 between men and women; men have a slightly higher unemployment than women.

People living at less than 200% of the Federal Poverty Level are nearly 4 times more likely to be unemployed than people living with incomes at 400% or greater of the Federal Poverty Level.

Most people of color are more likely to be unemployed than White/Caucasian people. Only Asian/Pacific Islander people had lower percentage of unemployment than White/Caucasian.

The disparity ratio between White/Caucasian and other ethnicities is below the target rate of 1.7 except for Hispanic/Latinx.

Note: HNC 2030 used U.S. Census, American Community Survey, five-year average unemployment percentages.

CURRENT DATA TRENDED OVER TIME

Figure 16. Disparity ratio among race/ethnicities for percent of population aged 16 and older in North Carolina who are unemployed but seeking work (2010 - 2020)

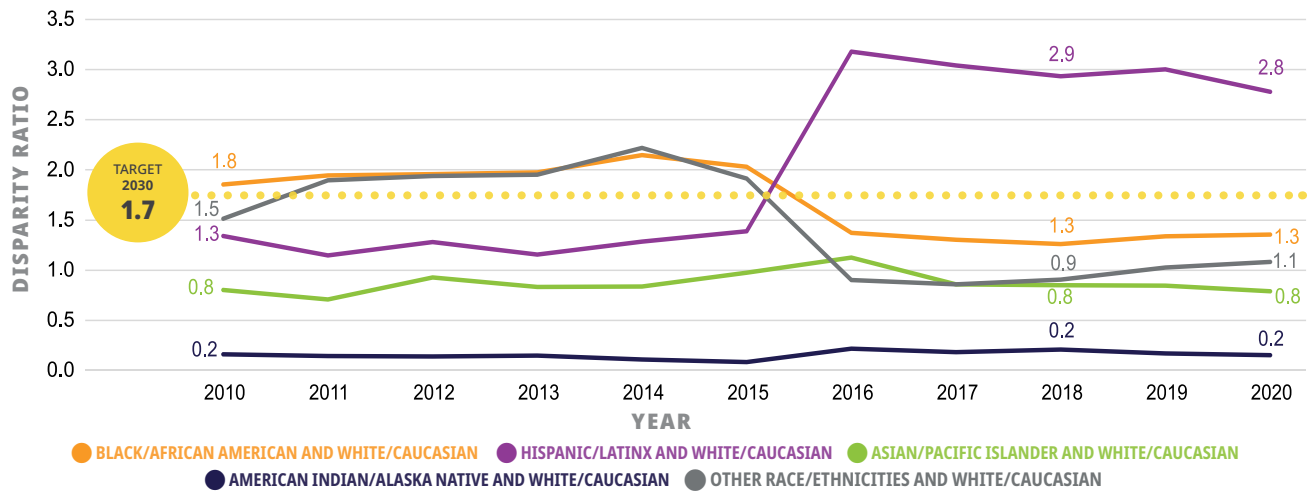


Figure 17. Percent of population aged 16 and older who are unemployed but seeking work in North Carolina by race/ethnicity (2010 - 2020)

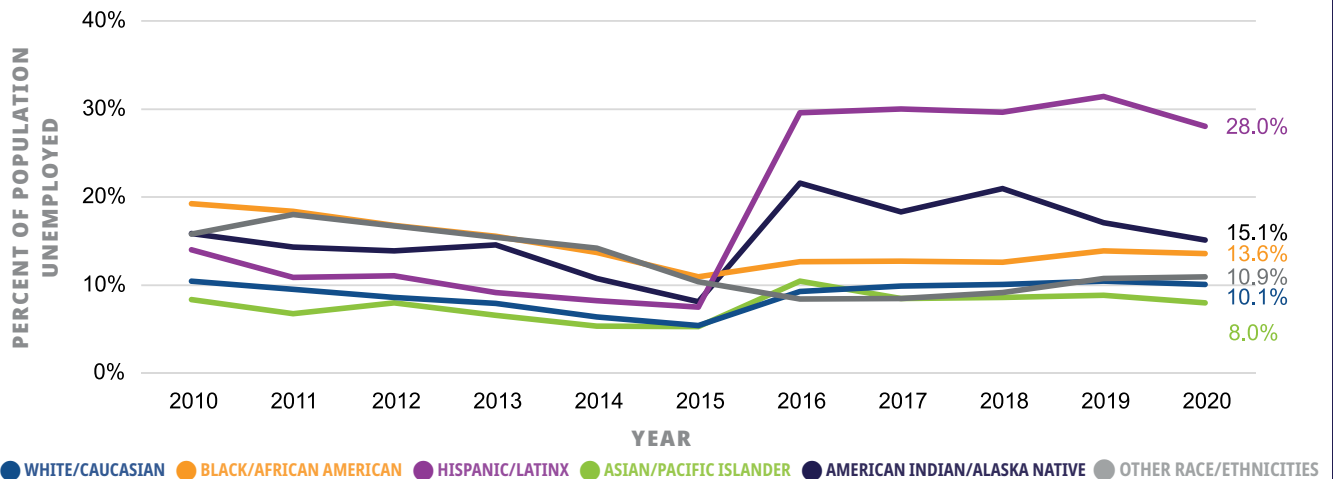


Figure 18. Percent of population aged 16 and older who are unemployed but seeking work in North Carolina by gender (2010 - 2020)

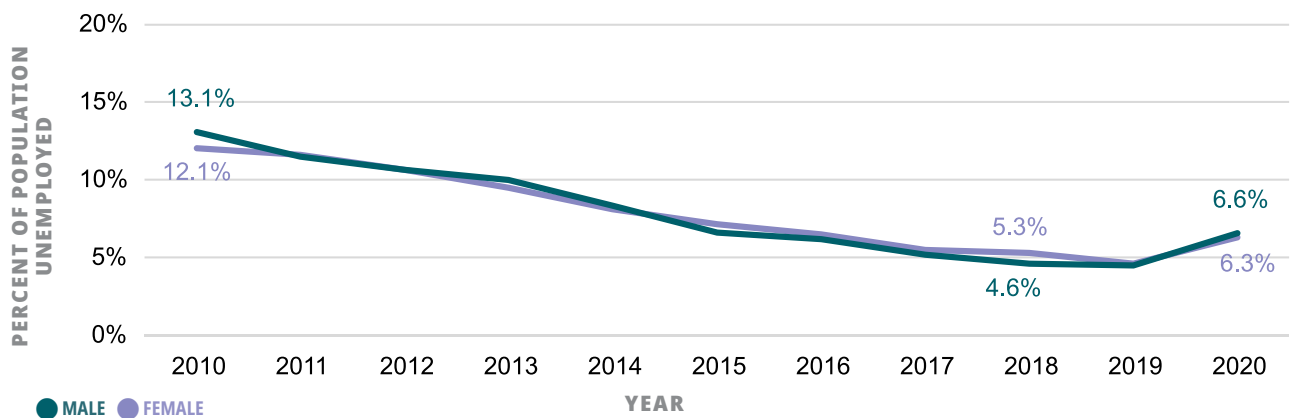


Figure 19. Percent of population aged 16 and older who are unemployed but seeking work in North Carolina by poverty status (2010 - 2020)

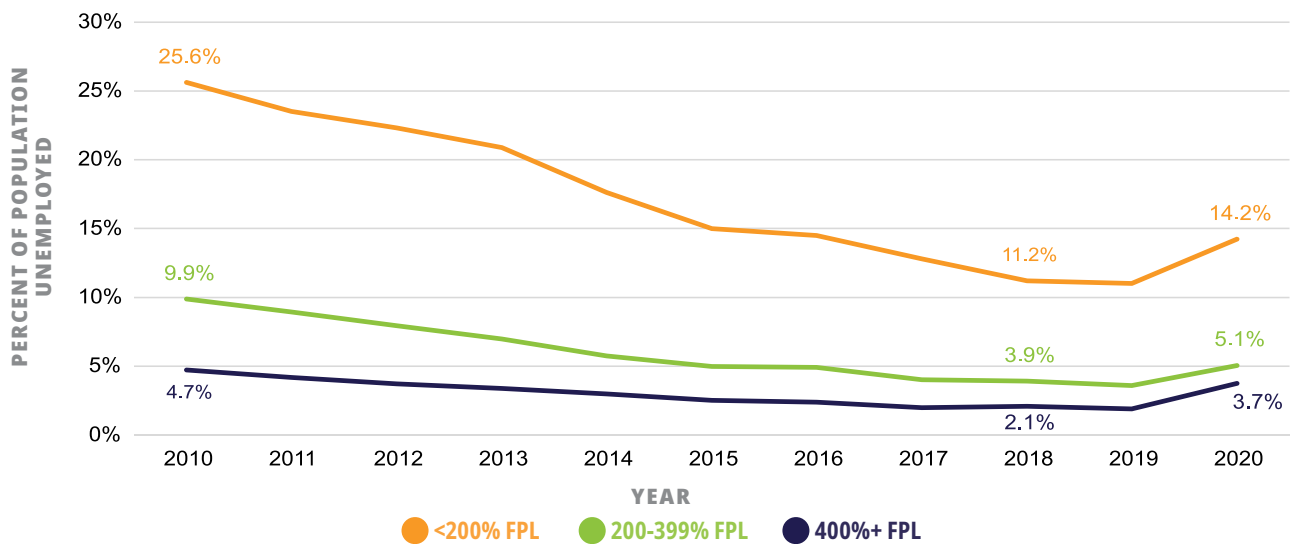
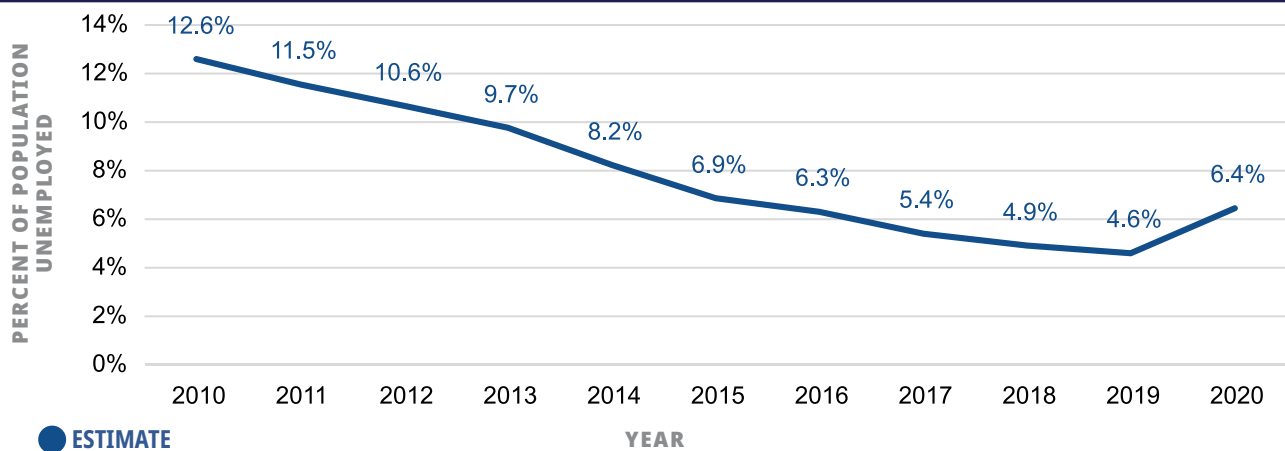


Figure 20. Percent of population aged 16 and older who are unemployed but seeking work in North Carolina (2010 - 2020)



THE STORY BEHIND THE CURVE

North Carolina needs a plan that “incorporates strategies to build a more resilient economy by focusing on rural communities and equitable, inclusive practices.”²

“Typical state economic development plans traditionally focus on issues such as industry recruitment strategies, incentives to encourage business expansion and relocation, support for the development of industrial properties, and state tax policies – all very important activities.... Every business survey conducted – nationally and in-state – identifies acquiring and growing the right talent as a crucial factor. The ability to find high-quality employees is essential to a business’s success. It is also what enables individuals and communities to advance their economic situation – making it the single most important issue to ensure North Carolina’s competitiveness.”³

“The North Carolina Department of Commerce outlines three goals to guide the state’s strategy:

1. Prepare North Carolina’s workforce for career and entrepreneurial success.
2. Prepare North Carolina’s businesses for success by growing and attracting a talented workforce.
3. Prepare communities across North Carolina to be more competitive in growing and attracting a talented workforce and businesses.”⁴

WHAT OTHER DATA DO WE NEED?

- Availability of job programs statewide
- Sources for minority-owned businesses
- Resources for financial counseling/wealth building for minorities
- Amount of childcare subsidy assistance provided for economically challenged working parents
- Amount and sources of post-secondary education support for economically challenged
- Geocoded data showing distribution of broadband internet

WHAT COULD WORK TO TURN THE CURVE?

- Create and expand legislation and advocate with employers to provide paid family medical leave, earned paid sick leave, kin care, and safe days for all caregivers
- Expand access to higher educational opportunities
- Expand transit options in rural and low-income communities
- Improve access to personal finance credit scores
- Increase access to affordable childcare
- Increase access to broadband internet
- Pass fair chance hiring policies for county and local employees, and work with employers to pass fair chance hiring policies for themselves
- Seek a national health insurance / national service program, e.g., An Economic Bill of Rights for the 21st Century
- Shift funding from industrial recruitment to support small businesses and social enterprises
- Support people with disabilities and those in recovery to live their lives as fully included members of the community by implementing key employment initiatives like Competitive Integrated Employment and Employment First

RECOMMENDED READING/LISTENING

2021 Annual Economic Development Partnership of North Carolina (EDNCP) Annual Report: Together We Thrive: <https://edpnc-thrive.com/>

Economic Development Partnership of North Carolina (EDNCP)[Promotional Video]. <https://edpnc.com/experience-all-in/>

North Carolina Department of Commerce. (July 2021). *First in talent. Strategic economic development plan for the state of North Carolina*. <https://www.nccommerce.com/documents/first-talent-strategic-economic-development-plan-state-north-carolina>

U.S. Department of Health and Human Services. (2021). *Community health and economic prosperity: Engaging businesses as stewards and stakeholders—A Report of the Surgeon General. Executive summary*. <https://www.hhs.gov/sites/default/files/chep-sgr-executive-summary.pdf>

Zamarripa, R. and Roque, L. (March 5, 2021). *Latinos face disproportionate health and economic impacts from COVID-19*. Center for American Progress. <https://www.americanprogress.org/article/latinos-face-disproportionate-health-economic-impacts-covid-19/>

NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
Care4Carolina	https://care4carolina.com/all-resources/
Economic Development Partnership of North Carolina	https://edpnc.com/
Green Opportunities	https://www.greenopportunities.org/jobtraining/
Hinton Rural Life Center	https://www.hintoncenter.org/
Just Economics of Western North Carolina	https://www.justeconomicswnc.org/issues/living-wage/
NCCARE360	https://nccare360.org/
North Carolina Association of County Directors of Social Services (NCACDSS)	https://www.ncacdss.org/
North Carolina Department of Commerce	https://www.nccommerce.com/
Open Integration Coalition, Inc.	https://www.oic-inc.com/
Raising Wages NC	https://raisingwagesnc.org/our-coalition
The Broadband ReConnect Program	https://www.usda.gov/reconnect

WHAT RESULT DO WE WANT?

All people in North Carolina are supported by a K-12 educational system that values diversity, equity, and inclusion for its students, faculty, staff, and communities.

WHY IS THIS IMPORTANT?

School disciplinary action is a strong predictor of student academic performance and high school completion. Less education can lead to fewer opportunities for high-paying employment that provides health insurance and access to other social support.¹

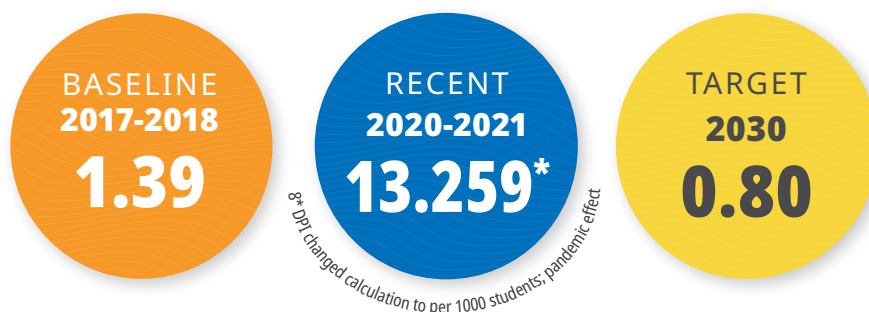
HNC 2030 HEADLINE INDICATOR:
The short-term suspension rate in middle and high school educational facilities

WHAT DOES THIS INDICATOR MEASURE?

A short-term suspension means that the student is out-of-school for 10 days or less. The rate is derived from a count of the number of short-term suspensions and may reflect multiple suspensions by one or more students. The data includes suspensions across all grades:

- Data are disaggregated by grade, race, gender, socioeconomic status, and disability
- No student level data – just rates per 1000 students

BASELINE DATA FROM HNC 2030



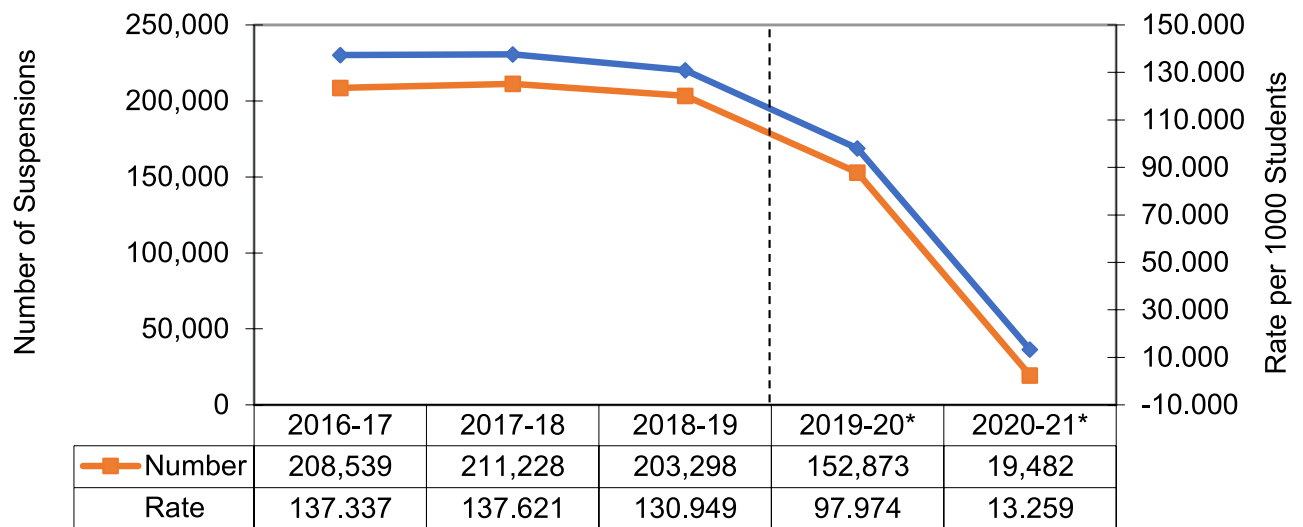
HOW ARE WE DOING?

While most of the visualized data in [Figure 21 - 24](#) represent suspensions, not numbers of unique students, it is important to note that of the 19,482 short-term suspensions in 2020-2021 school year, 15,128 individual students were affected by these short-term suspensions for an average of 1.29 short-term suspensions per student. The average duration of a single short-term suspension was 2.84 days.²

CURRENT DATA TRENDED OVER TIME

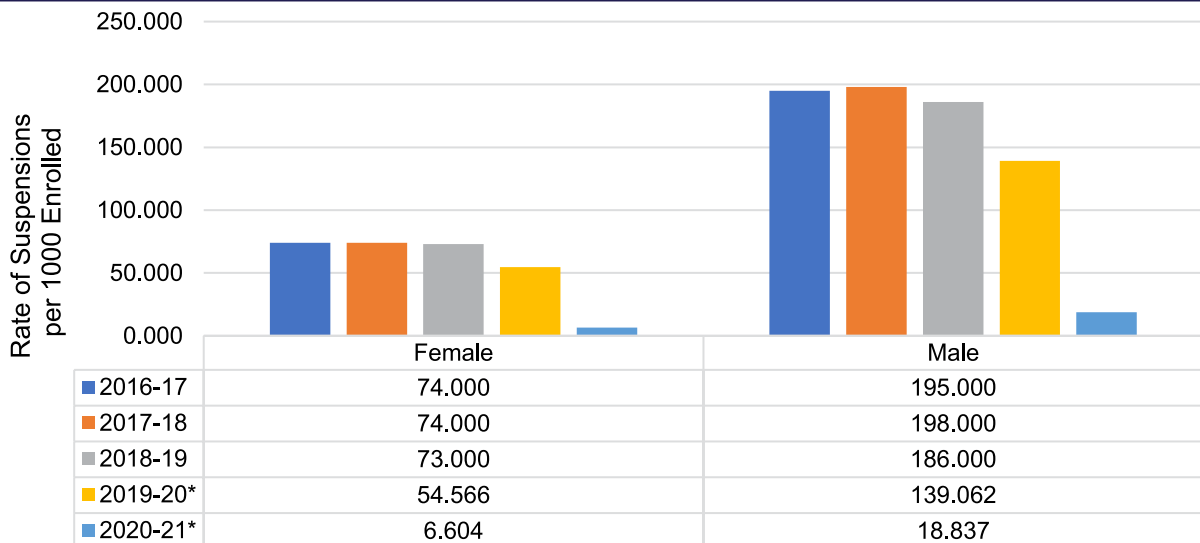
Figures 21-24 were reproduced with permission from the NC Department of Public Instruction Center for Safer Schools.³⁻⁶

Figure 21. Short-term suspensions for all acts reported, 2016-2017 to 2020-2021



Note: *In response to the COVID-19 pandemic, starting in March of the 2019-2020 school year and continuing through the 2020-2021 school year, public school units across the state employed unprecedented methods to ensure continued student learning by utilizing various modes of instruction and student outreach. As such, caution should be taken when comparing data reported for the 2019-2020 and 2020-2021 school years to data reported for prior and subsequent years.

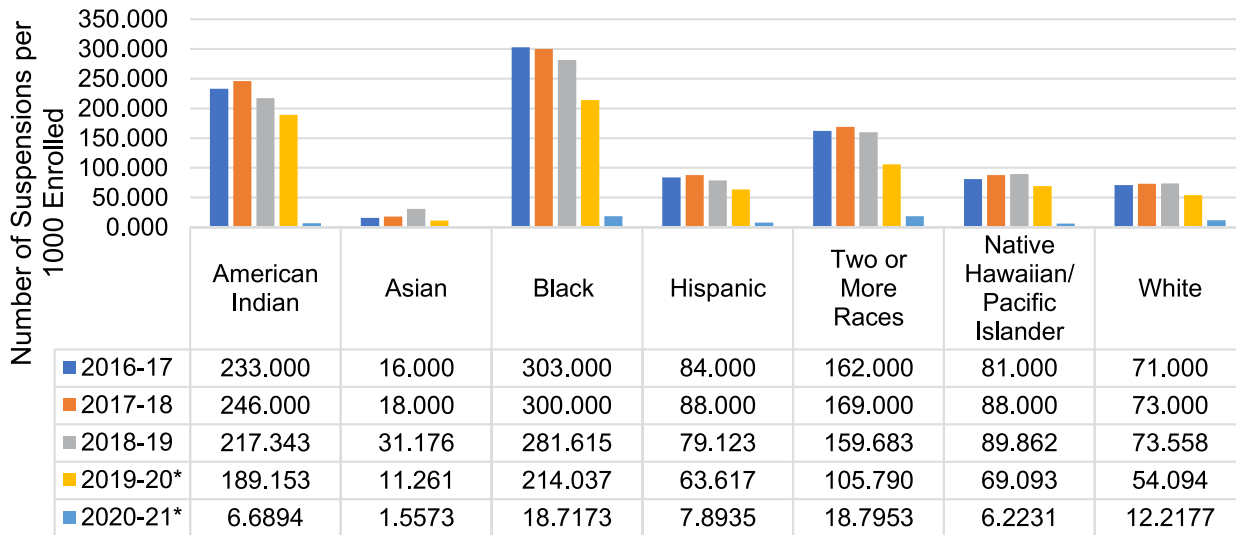
Figure 22. Short-term suspension rate (per 1,000 enrolled), by gender



Consistent with previous years, males received more short-term suspensions than females in 2020-2021. The rate of short-term suspensions for male students was 2.85 times the rate for females in 2020-2021. In 2020-2021, both the rate and number of short-term suspensions for both males and females decreased from the previous academic year.

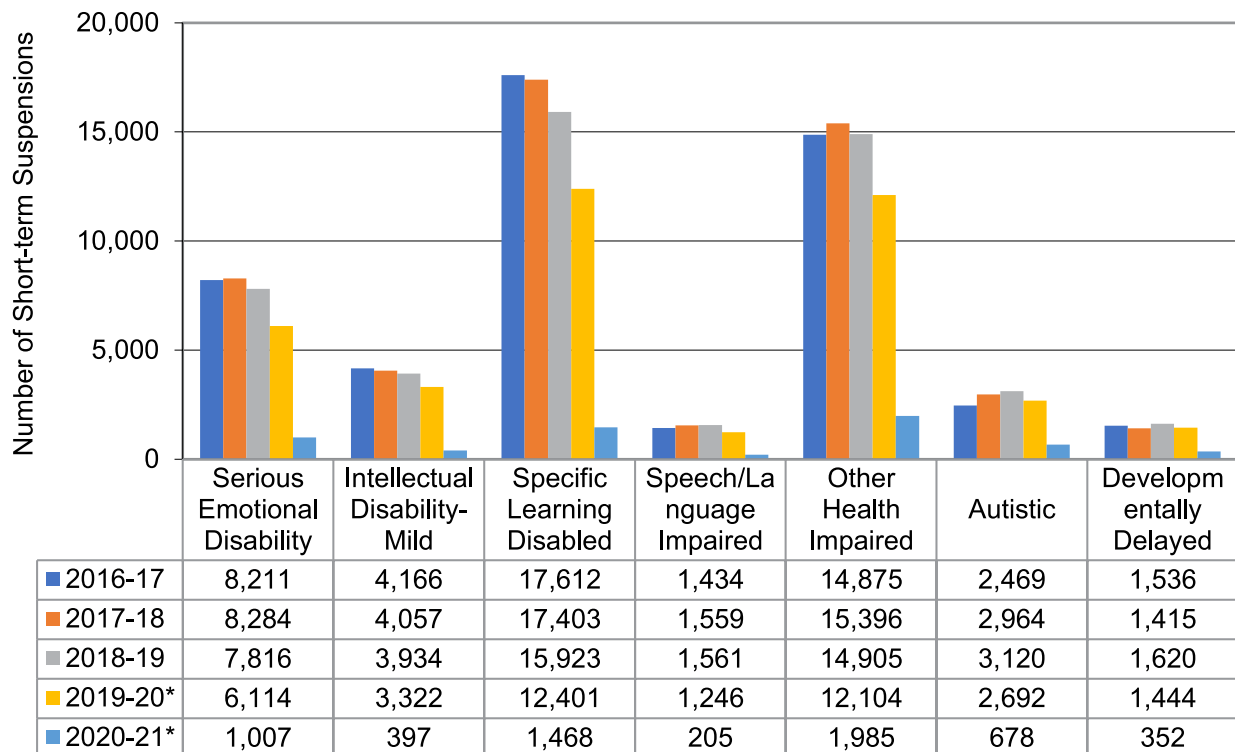
SHORT TERM SUSPENSIONS

Figure 23. Short-term suspensions rate (per 1,000 enrolled) by race/ethnicity



In 2020-2021, the rate of short-term suspensions for all race/ethnicities decreased when compared to the previous academic years. The largest decrease was for Asian students (19.5%), Black students (91.3%) and Native Hawaiian/Pacific Islander students (91.0%).

Figure 24. Short-term suspensions by exceptional children (EC) status



In 2020-2021, 32.1% of short-term suspensions were given to exceptional children. This percentage is higher than the 27.6% in the 2019-2020 academic year. The number of short-term suspensions decreased for the seven exceptional children categories most frequently reported.



LET'S SHIFT THE PERSPECTIVE FROM "WHAT IS WRONG WITH YOU?" TO "WHAT HAS HAPPENED TO YOU?"

- Blodgett & Dorado, 2016, p. 59

THE STORY BEHIND THE CURVE

"Trauma-informed school-wide interventions are associated with decreased office discipline referrals, physical aggression incidents, and out-of-school suspensions."⁷ Suspensions are often linked to adverse childhood experiences (ACEs). Blodgett & Dorado (2016) reviewed the literature for trauma-informed school practice and alignment with educational practice.⁸ Communities with higher ACE scores had "higher rates of suspension and unexcused absences and lower rates of graduation from high school and progression to post-secondary school than communities with relatively low prevalence of ACEs."⁹

WHAT OTHER DATA DO WE NEED?

Additional data is needed to confirm the effects of trauma-informed school-wide interventions, especially on student outcomes. We are very early in a paradigm shift in education policy and practice that requires strong science to develop a unifying framework for educational reform.

WHAT COULD WORK TO TURN THE CURVE?

- Develop statewide system of restorative justice programs
- Disrupt the school-to-prison pipeline, beginning with preschool, by reducing the use of school suspensions and expulsions and increasing the use of counseling services
- Implement trainings and policies for trauma-informed schools
- Increase racial, ethnic, gender, and disability status diversity among school and childcare leadership and staff and the institutions that train them
- Include suspension rate in measures of school quality
- Support systemwide training throughout the education system to raise awareness of implicit bias

RECOMMENDED READING/LISTENING

Blodgett, C. & Dorado, J. (2016). A selected review of trauma-informed school practice and alignment with educational practice. California Endowment: San Francisco, CA. <https://s3.wp.wsu.edu/uploads/sites/2101/2019/12/Selected-Review-of-Trauma-Informed-School-Practice-2016.pdf>

North Carolina Department of Public Instruction, Center for Safer Schools, Consolidated Data Report (2020-2021) <https://www.dpi.nc.gov/media/14171/open>

Robert Wood Johnson Foundation – County Health Rankings What Works for Health
<https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies?f%5B0%5D=health-factor%3AEducation>

NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
Center for Racial Equity in Education (CREED)	https://www.creed-nc.org/
Color of Education	https://colorofeducation.org/
Made in Durham	https://madeindurham.org/
North Carolina Department of Public Instruction	https://www.dpi.nc.gov/
Public School Forum of North Carolina	https://www.ncforum.org/
Racial Equity Institute, LLC	https://www.racialequityinstitute.com/
Southern Coalition for Social Justice-Youth Justice Project	https://southerncoalition.org/youth-justice-project/
The Center for Youth, Family, and Community Partnerships (CYFCP)	https://cyfcp.uncg.edu/
Village of Wisdom	https://www.villageofwisdom.org/
Working to Extend Anti-Racist Education (we are)	https://www.weare-nc.org/

WHAT RESULT DO WE WANT?

North Carolina embraces a fair and equitable justice system, free from racism and bias, where safety is foundational to all aspects of a free society, and all communities are free from harm and violence.

WHY IS THIS IMPORTANT?

"People of color, notably African American men, are imprisoned at disproportionate rates and tend to face harsher punishment for similar crimes as their white counterparts. There are enormous health, social, and economic consequences of incarceration for both the imprisoned person, their families, and our communities."¹

HNC 2030 HEADLINE INDICATOR:
Number of people aged 13 and older entering North Carolina prisons per 100,000 population

WHAT DOES THIS INDICATOR MEASURE?

The indicator measures the rate of incarceration for people aged 13 years and older who enter the N.C. prison system during a calendar year. The rates are based on the jurisdictional population with sentence greater than one year. The data are obtained from the N.C. Department of Public Safety Automated Query System which is updated every six months.

<https://webapps.doc.state.nc.us/apps/asqExt/ASQ>

The data can be disaggregated by :

- Race/Ethnicity
- Gender
- Prison Entries/Prison Exits/Prison Populations
- Age/Age Group
- Citizenship
- Country of Birth
- County of Conviction
- County of Residence
- Crime Category
- Marital Status

BASELINE DATA FROM HNC 2030



HOW ARE WE DOING?

The overall rate of incarceration in N.C. prisons has seen a significant drop from 347 per 100,000 population aged 13 and older in 2011, to 272/100,000 in 2019. An even greater drop occurred in 2020 with an overall incarceration rate in N.C. prisons of 163/100,000 population. The drop in 2020 is mostly related to the impact of the COVID-19 pandemic and its effect on the court system.

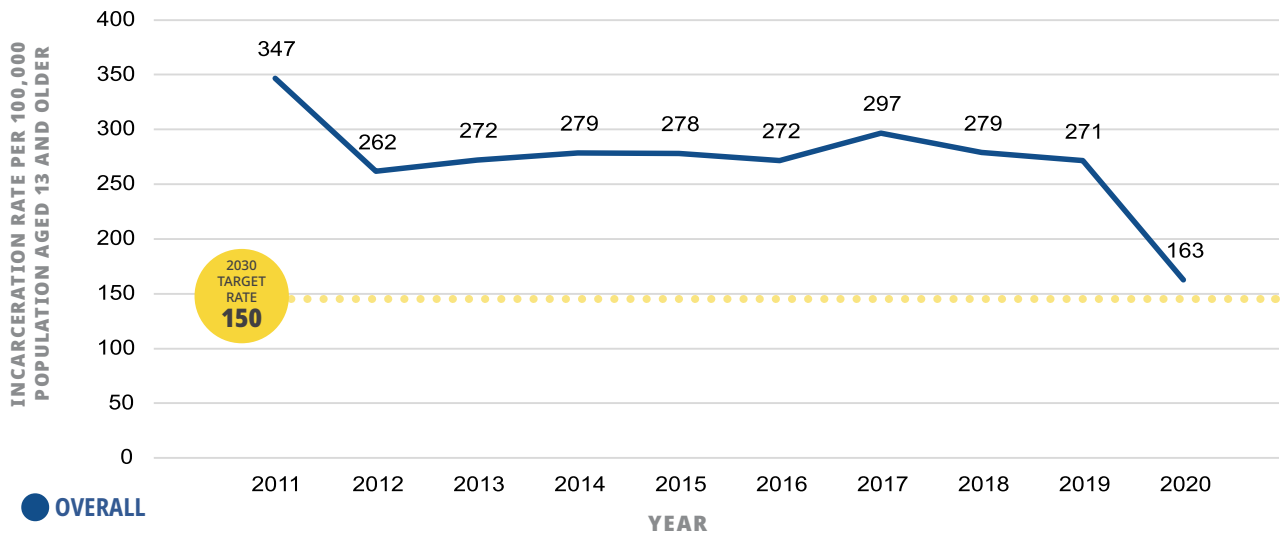
The incarceration rate for females has been stable with only small variations in the rates from 2011-2019.

The rate of incarceration for males dropped significantly from 632/100,000 population in 2011, to 271/100,000 population in 2019.

Black/African American people continue to have higher rates of incarceration than White/Caucasian or Hispanic people. The rate of incarceration of Black/African American people was 824/100,000 population in 2011 but dropped to 529/100,000 in 2019.

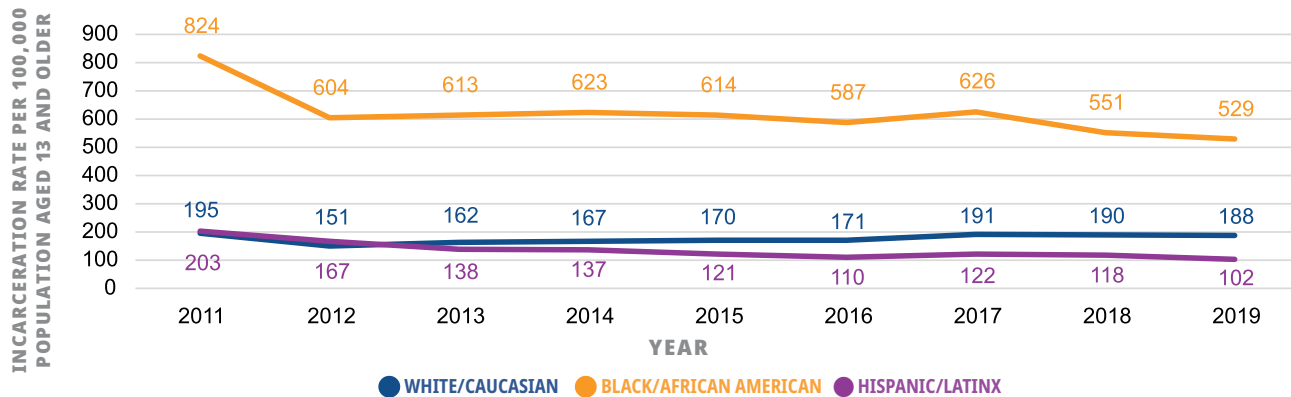
CURRENT DATA TRENDED OVER TIME

Figure 25. Incarceration rate in North Carolina prisons (2011 - 2020)



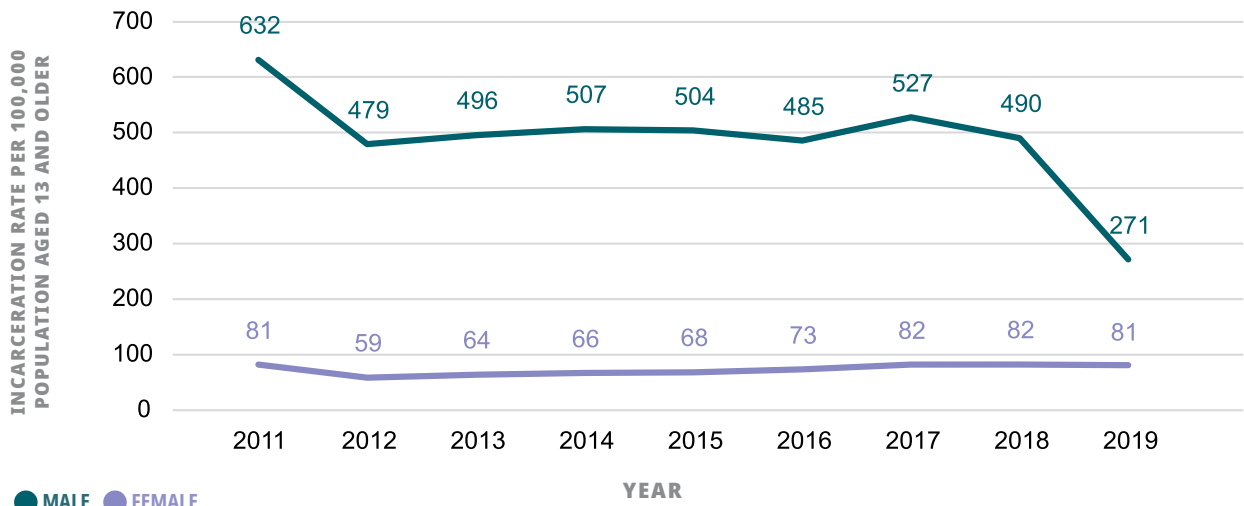
Data source: N.C. Department of Public Safety, N.C. State Center for Health Statistics, Vital Statistics, and National Center for Health Statistics (CDC bridged race population).

Figure 26. Incarceration rate in North Carolina prisons by race/ethnicity (2011 - 2019)



Data source: N.C. Department of Public Safety, N.C. State Center for Health Statistics, Vital Statistics, and National Center for Health Statistics (CDC bridged race population).

Figure 27. Incarceration rate in North Carolina prisons by gender (2011 - 2019)



Data source: N.C. Department of Public Safety, N.C. State Center for Health Statistics, Vital Statistics, and National Center for Health Statistics (CDC bridged race population).

THE STORY BEHIND THE CURVE

According to SAMHSA, an estimated 18% of the general population has a mental illness. However, an estimated 44% of those in jail and 37% of those in prison have a mental illness.²

An estimated 11% of the 18–25-year-old population, and 6% of those over 25 years old have a substance use disorder. The estimated prevalence of substance use disorder in jails is 63% , and 58% in prisons.³

People with these disorders have challenges in getting appropriate treatment and often incarceration exacerbates their symptoms. This can lead to individuals staying incarcerated longer than those without behavioral health concerns. Upon release from incarceration, people with behavioral health issues face many barriers to successful reentry into the community, such as lack of health care, job skills, education, stable housing, and poor connection with community behavioral health providers. These factors may jeopardize their recovery and increase their probability of relapse and re-arrest.⁴

WHAT OTHER DATA DO WE NEED?

- Impact of COVID-19 pandemic on prison population
- Demographics about people incarcerated or detained by the U.S. Marshals Service (USMS) and Immigration and Customs Enforcement (ICE)
- Prison and jail population by state/year: <https://www.vera.org/publications/people-in-jail-and-prison-in-2020>
- Incarceration in local jails and state prisons: <https://www.vera.org/publications/state-incarceration-trends>
- Descriptive statistics that capture racial equity training provided for court system personnel
- Methodology for reporting racial data in the Administrative Office of the Courts
- Inventory of policies regarding use of force and duty to report excessive use of force at every level of the justice system
- Annual report of school-based offenses in public schools
- Inventory of mental health and substance use disorder services (screening and treatment) provided in jail health settings

WHAT COULD WORK TO TURN THE CURVE?

- Ensure access to behavioral health treatment, adequate medical care, and stable housing for those returning from incarceration
- Expand existing or create community Medication Assisted Treatment programs for those people detained in correctional facilities
- Implement standardized, evidence-based programs to reduce recidivism
- Improve access to treatment for substance use disorders, physical illnesses, and mental illnesses
- Improve conditions in jails and prisons to reduce harmful impact of incarceration and foster successful reintegration into the community
- Improve educational outcomes, particularly for young men and boys of color
- Increase access to multi-systemic therapy for juvenile offenders
- Invest in public health alternatives to traditional law enforcement and sentencing, particularly for behavioral health issues
- Reduce intergenerational and neighborhood poverty
- Secure funding to develop policies and practices that enhance the courts' capacity to respond to victims and others who have experienced trauma



“THE DATA SHOW THAT WE ARE GOING IN THE RIGHT DIRECTION, BUT JUST NOT FAST ENOUGH.”

- 2021 NC SHIP Symposia participant

RECOMMENDED READING/LISTENING

Kang-Brown, J., Montagnet, C., and Heiss, J. (2020, January). People in jail and prisons. People-in-Jail-and-Prison-2020-Revised-2.pdf (vera.org)

North Carolina Department of Justice. (2021, December). North Carolina task force for racial equity in criminal justice: End of year report 2021. <https://ncdoj.gov/trec/reports/>

Vera Institute of Justice. Ending mass incarceration. <https://www.vera.org/downloads/pdfdownloads/state-incarceration-trends-north-carolina.pdf>

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (n.d.). Evidence-based practice resource center. People in the criminal justice system. <https://www.samhsa.gov/resource-search/ebp>

NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
Durham County NC Criminal Justice Resource Center Growing Change, Inc	https://www.dconc.gov/county-departments/departments-a-e/criminal-justice-resource-center
Leading Into New Communities (LINC), Inc.	https://www.growingchange.org/
National Council of Juvenile and Family Court Judges	https://lincnc.org/
(NCJFCJ)-Trauma- Informed Courts	https://www.ncjfcj.org/child-welfare-and-juvenile-law/trauma-informed-courts/
North Carolina Department of Public Instruction (NC DPI)	https://www.dpi.nc.gov/data-reports/discipline-alp-and-dropout-data
North Carolina Harm Reduction Coalition (NCHRC)	https://www.nchrc.org/
North Carolina Judicial Branch- School Justice Partnership	https://www.nccourts.gov/programs/school-justice-partnership
North Carolina Justice Academy	https://ncdoj.gov/ncja/
North Carolina Task Force for Racial Equity in Criminal Justice (TREC)	https://ncdoj.gov/trec/
Wash Away Unemployment	https://www.wash-away.org/

WHAT RESULT DO WE WANT?

All children in North Carolina thrive in safe, stable, and nurturing environments.

WHY IS THIS IMPORTANT?

Numerous studies have found a consistently strong relationship between an increasing number of Adverse Childhood Experience (ACEs) and poor health outcomes in adults. While the National Survey of Children's Health does not capture the timing of ACEs or the onset of poor health outcomes, a similar dose-response relationship is found between ACEs and health outcomes in children. In 2017-2018, the percentage of children with complex or poor physical and social-emotional health increased as the number of parent-reported ACEs increased. For example, 14.3% of children with no ACEs had special health care needs, increasing to 43.5% among children with four or more ACEs. The same pattern was found between number of ACEs and poorly rated physical health, difficulty making and keeping friends, behavior or conduct problems, anxiety, and depression.¹

HNC 2030 HEADLINE INDICATOR:

Percent of children with two or more adverse childhood experiences

WHAT DOES THIS INDICATOR MEASURE?

Indicator is percentage of children having experienced at least two of the following:

- Parent/guardian divorced or separated
- Parent/guardian died
- Parent/guardian served time in jail
- Saw or heard parents or adults slap, hit, kick, punch one another in the home
- Was a victim of violence or witnessed violence in his or her neighborhood
- Lived with anyone who was mentally ill, suicidal, or severely depressed
- Lived with anyone who had a problem with alcohol or drugs
- Was treated or judged unfairly because of his or her race or ethnic group

BASELINE DATA FROM HNC 2030



HOW ARE WE DOING?

The Overall, the percentage of children with two or more adverse childhood experiences is trending downward, with an estimate of 23.6% in 2016 - 2018 to 16.6% in 2019 - 2020.

Data for race/ethnicity shows that the highest percentage of adverse childhood experiences is reported for Black/African American and "other." The percentage is almost twice as high for these race/ethnicity groups compared to the White/Caucasian group.

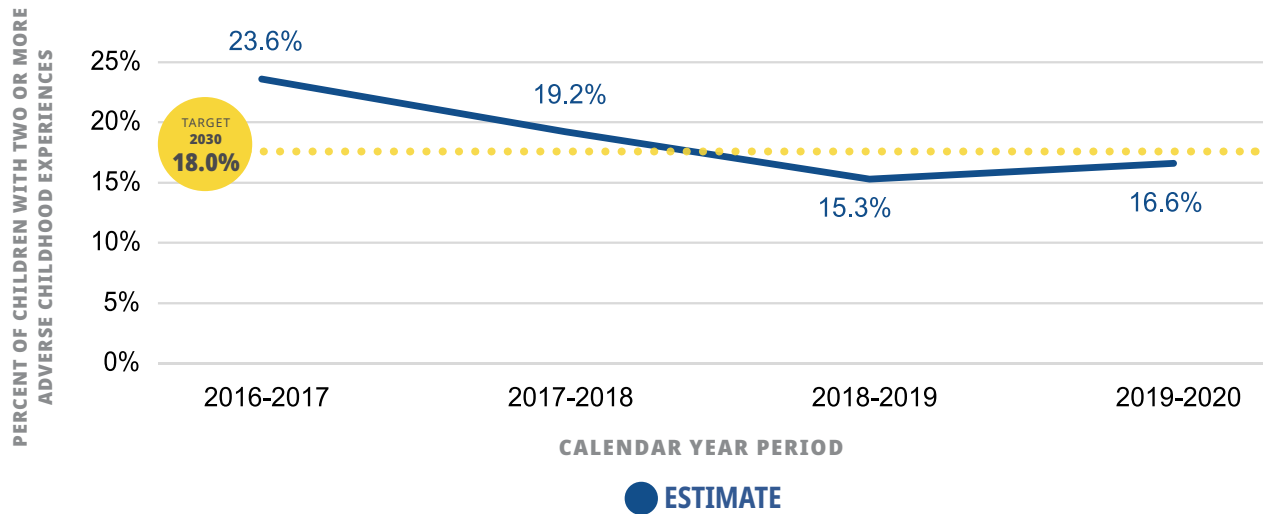
The percentage of children in families with the lowest household incomes are impacted 3.5 times more by adverse childhood experiences than children from families with higher household incomes.

The data show that the percentage of adverse childhood experiences by gender are almost equivalent, with a slight increase in percentage for females in 2019 - 2020.

Even though this indicator is trending in the right direction, there is a significant difference between Black/African American children and White/Caucasian children. The data point to a correlation between family household income, and the percentage of adverse childhood experiences reported.

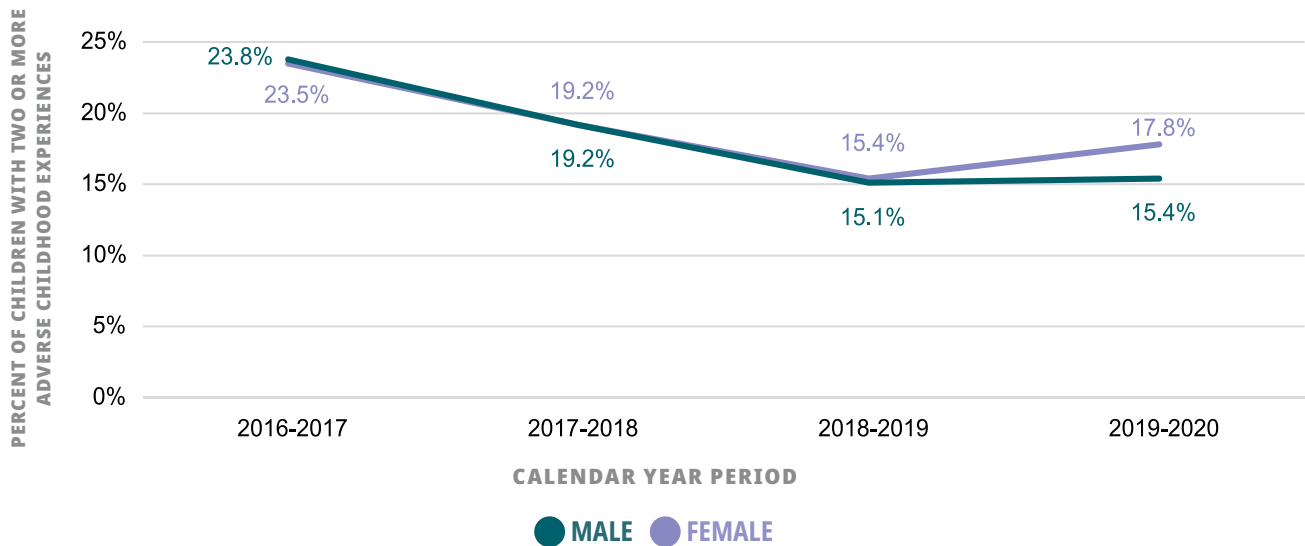
CURRENT DATA TRENDED OVER TIME

Figure 28. Percent of children with two or more adverse childhood experiences in North Carolina (2016 - 2020)



Percentages and population estimates are weighted to represent child population in the United State of America. Data Source: : National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau. <https://mchb.hrsa.gov/data/nationalsurveys>

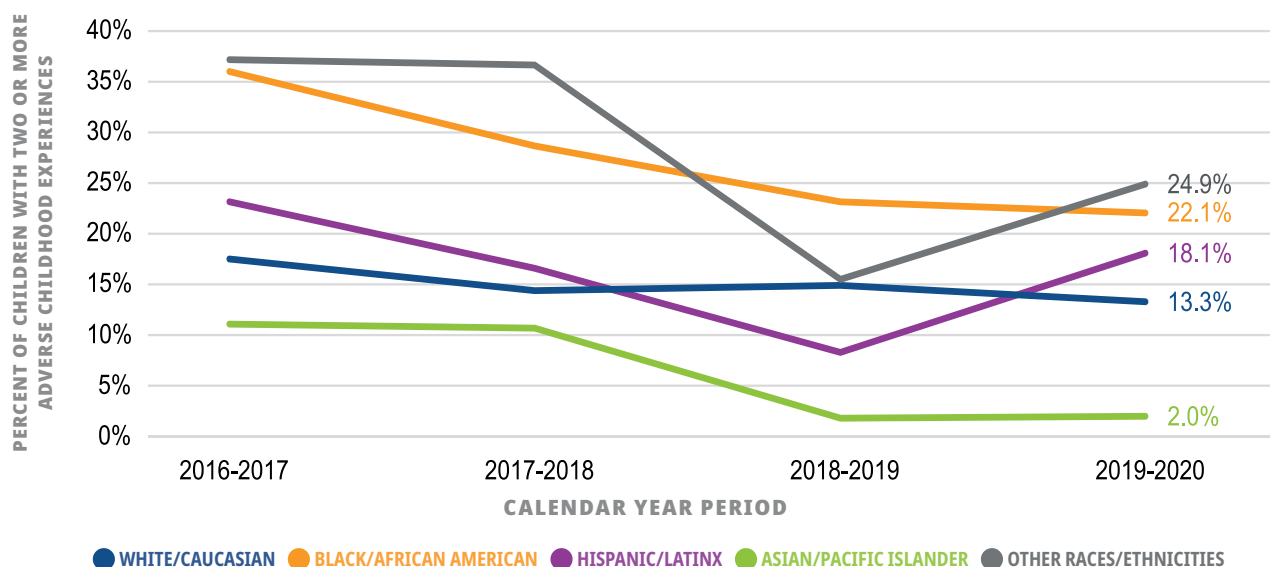
Figure 29. Percent of children with two or more adverse childhood experiences in North Carolina by gender (2016 - 2020)



Percentages and population estimates are weighted to represent child population in the United State of America. Data Source: : National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau. <https://mchb.hrsa.gov/data/nationalsurveys>

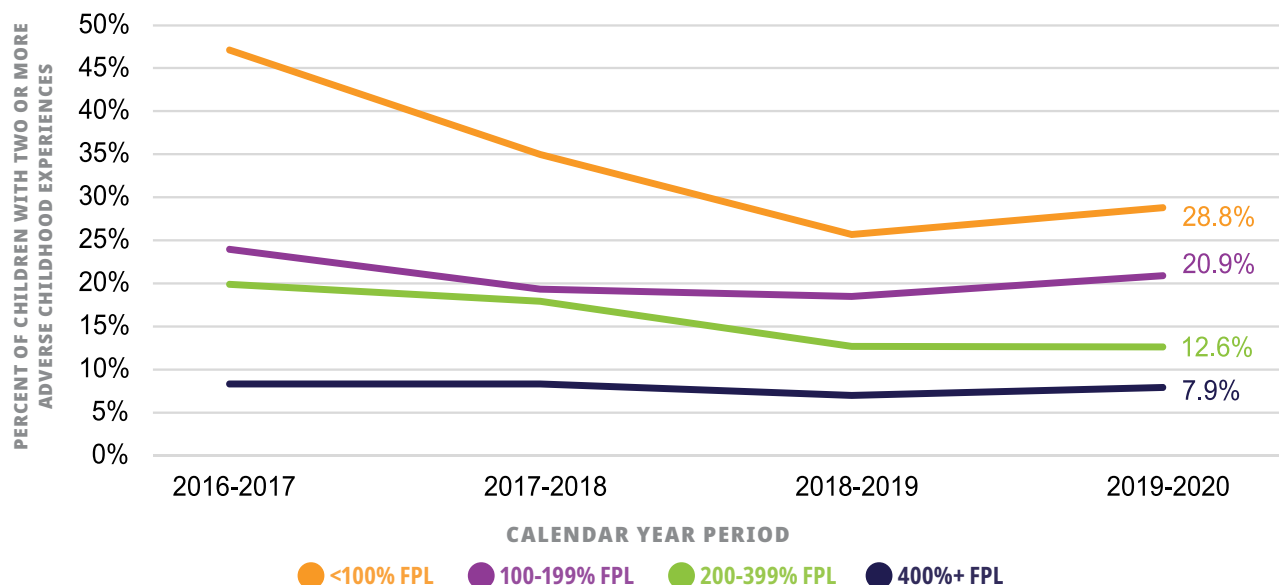
ADVERSE CHILDHOOD EXPERIENCES

Figure 30. Percent of children with two or more adverse childhood experiences in North Carolina by race/ethnicity (2016 - 2020)



Data unavailable for American Indian/Alaska Natives. Percentages and population estimates are weighted to represent child population in the United States of America. Data source: : National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau. <https://mchb.hrsa.gov/data/nationalsurveys>

Figure 31. Percent of children with two or more adverse childhood experiences in North Carolina by poverty level (2016 - 2020)



Percentages and population estimates are weighted to represent child population in the United State of America. Data Source: : National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau. <https://mchb.hrsa.gov/data/nationalsurveys>

THE STORY BEHIND THE CURVE

"Childhood adversity changes our biological systems – those with higher ACE scores have greater health risks over the course of a lifetime."²

Research consistently shows that ACEs are common.³

"Historical and ongoing traumas due to systemic racism and discrimination or the impacts of multigenerational poverty resulting from limited educational and economic opportunities intersect and exacerbate the experience of other ACEs, leading to disproportionate effects in certain populations (Nuriyous, Logan-Greene, and Green, 2012, as cited in CDC, 2020)."⁴

WHAT OTHER DATA DO WE NEED?

NC DHHS, in partnership with a diverse set of stakeholders, developed a standardized set of social determinants of health screening questions ([Appendix A](#)) to address and acquire data on the following:

- Food insecurity
- Housing instability
- Lack of transportation
- Interpersonal violence

WHAT COULD WORK TO TURN THE CURVE?

- Expand community and domestic violence prevention programs
- Increase access to behavioral health treatment
- Increase access to children's mental health services by expanding mental health services in primary care, schools, and specialty care
- Increase access to evidence-based parenting (including fatherhood programs), early intervention, and home visiting programs
- Increase minimum wage and employment opportunities
- Invest in better data to enhance ability to assess and address adverse childhood experiences
- Invest in care management and connections to treatment for families with substance use disorders who are involved in the Child Welfare System
- Strengthen Juvenile Crime Prevention Councils

RECOMMENDED READING/LISTENING

Bellazaire, A. (2018, August). Preventing and mitigating the effects of adverse childhood experiences. National Conference of State Legislatures. https://www.ncsl.org/Portals/1/HTML_LargeReports/ACEs_2018_32691.pdf

Garner, A. and Yogman, M. (2021, August). Preventing childhood toxic stress: Partnering with families and communities to promote relational health. *Pediatrics*, 48,(2). <https://doi.org/10.1542/peds.2021-052582>

Harris, N.B. (2018). *The deepest well: Healing the long-term effects of childhood adversity*. Houton Mifflin Harcourt.

Substance Abuse and Mental Health Administration (SAMHSA). (2019, February). *Behavioral health services for American Indians and Alaska natives: Executive summary*. https://store.samhsa.gov/sites/default/files/d7/priv/tip_61_aian_full_document_020419_0.pdf

Trent, M., Dooley, D., and Douge, J. (2019, August 1). The impact of racism on child and adolescent health. *Pediatrics*, 144(2). <https://publications.aap.org/pediatrics/article/144/2/e20191765/38466/The-Impact-of-Racism-on-Child-and-Adolescent?autologincheck=redirected>

Van Der Kolk, Bessel. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Viking.

NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
Center for Child & Family Health	https://www.ccfhnc.org/
Kellin Foundation	https://www.kellinfoundation.org/
North Carolina Academy of Family Physicians	https://www.ncafp.com/
North Carolina Child Treatment Program	https://www.ncchildtreatmentprogram.org/
North Carolina Division of Child and Family Well-Being	https://www.ncdhhs.gov/divisions/division-child-and-family-well-being
North Carolina Homeless Education Program	https://hepnc.uncg.edu/
North Carolina Infant and Young Child Mental Health Association (NCIMHA)	https://www.ncimha.org/
North Carolina Judicial Branch- Chief Justice's Task Force on ACEs	https://www.ncahec.net/healthy-north-carolina-2030/
North Carolina Area Health Education Centers (NC AHEC)	https://www.ncahec.net/
North Carolina Pediatric Society	https://www.ncped.org/
North Carolina Psychological Foundation	https://www.ncpsychology.org/
Our Children's Place of Coastal Horizons Center	https://coastalhorizons.org/
Parenting Inside Out	http://www.parentinginsideout.org/
The National Conference for Community and Justice of the Piedmont Triad, Inc. (NCCJ of the Piedmont Triad)	https://www.nccjtriad.org/programs/
The North Carolina Partnership for Children, Inc. - Smart Start	https://www.smartstart.org/
Together for Resilient Youth (T.R.Y.)	https://try4resilience.org/
Wellness Recovery Action Plan (WRAP)	https://www.wellnessrecoveryactionplan.com/wrap-can-help/youth-children/
Winer Family Foundation	https://www.wffcharlotte.org/

WHAT RESULT DO WE WANT?

All children in North Carolina can discover the joy of reading at an early age and are supported in the home, school, and community to be lifelong readers.

WHY IS THIS IMPORTANT?

Children with low reading proficiency are more likely to drop out of high school, acquire low paying jobs that limit access to health care, and have increased risks for numerous adverse health outcomes.¹

HNC 2030 HEADLINE INDICATOR:
Percent of children reading at a proficient level or above based on third grade End-of-Grade exams in North Carolina

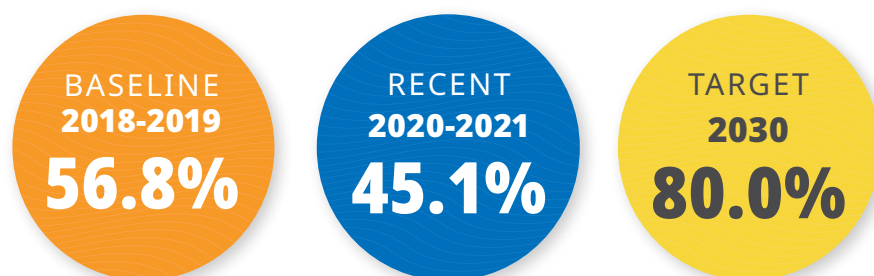
WHAT DOES THIS INDICATOR MEASURE?

The percentage of children grades three through five who have achieved a three or higher on END OF GRADE (EOG) testing for reading. A score of three is the minimum score required to be considered proficient.

Data are disaggregated by grade, race, gender, socioeconomic status, and disability.

The indicator uses NC Department of Public Instruction (DPI) percentages already calculated in the available DPI data set. Numerators and denominators are also available, along with a masking variable for proficiencies below 5%, proficiencies 95% or higher, and small denominators (<10).

The data can be located on NC DPI's website: <https://www.dpi.nc.gov/data-reports/school-report-cards/school-report-card-resources-researchers>

BASELINE DATA FROM HNC 2030**HOW ARE WE DOING?**

- According to the NC DPI's Office of Early Learning, for the first time in at least 10 school years, most of the state's first, second, and third-grade students did not demonstrate reading proficiency.²
- Disaggregated proficiency data reveal that low income, racial bias and inequity, disability, homelessness, and child abuse/neglect continue to create barriers to opportunity for North Carolina's children.³
- Persistent racial disparities in NC's third grade reading scores have changed little over the years.⁴
- The 2020–21 school year and the 2018–19 school year differed significantly with respect to (1) time frame for test administrations, (2) number of days between instruction and the test administration, and (3) instructional delivery mode. For these reasons, the 2018–19 test data is provided as a reference; it is intended for context, not for accountability or evaluation.⁵

CURRENT DATA TRENDED OVER TIME

Figure 32. Percent of children who are proficient in reading at the end of third grade across populations in North Carolina

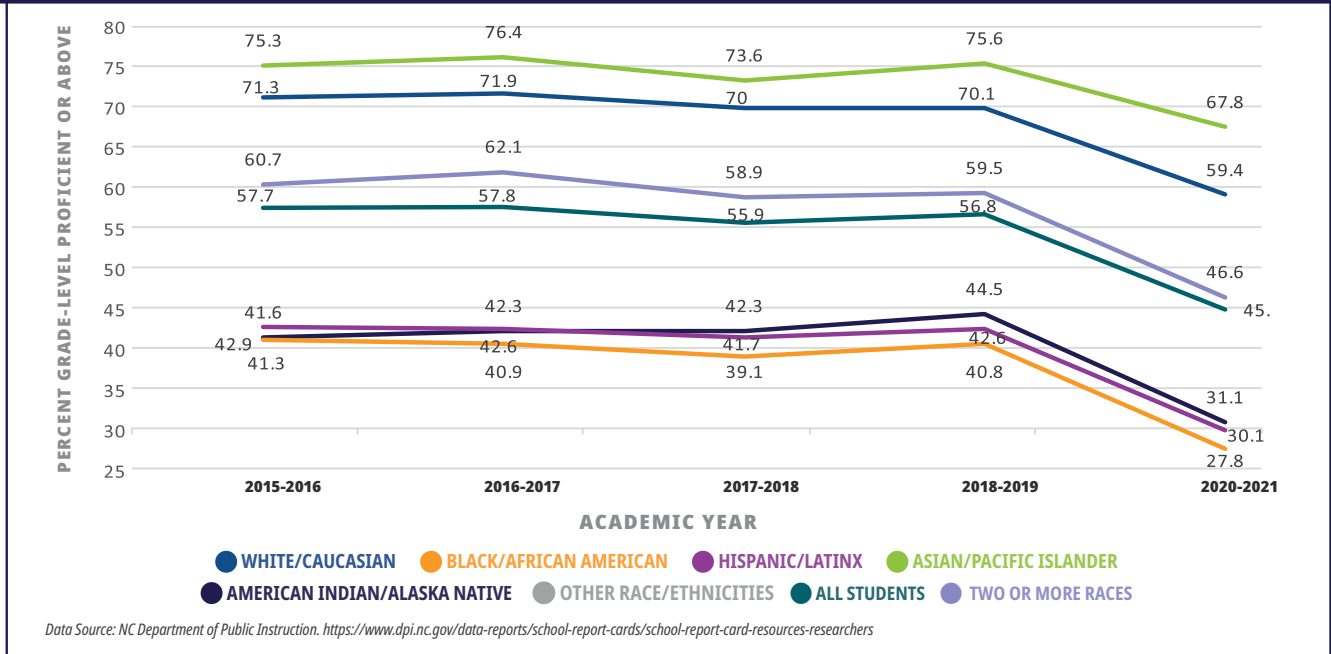
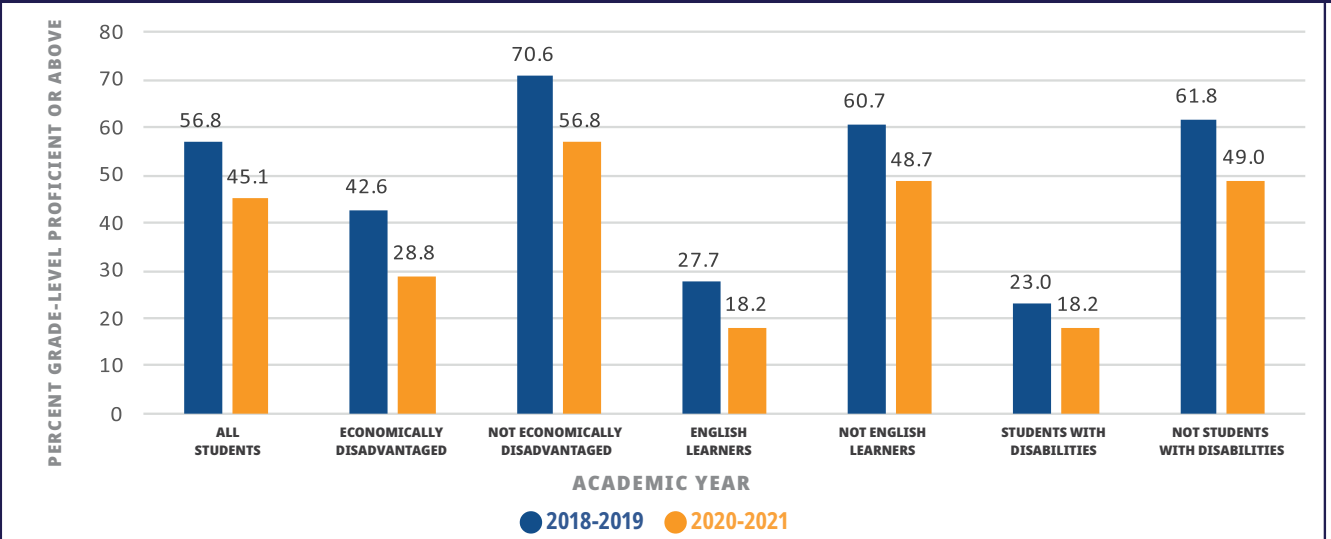


Figure 33. Percent of children who are proficient in reading at the end of third grade in North Carolina by select subgroups



THE STORY BEHIND THE CURVE

Dialogue from the 2022 NC SHIP Community Council Meeting and Symposia:

- Reading scores have been declining for over a decade
- Young children do not receive enough instruction in phonics to become fluent readers
- Fluency improves comprehension
- Reading is taught in a vacuum without giving students an opportunity to learn reading in science and history
- Home reading habits have deteriorated
- Cuts in spending for education generally mean cuts to personnel

"In 2019, results on national and international exams showed stagnant or declining American performance in reading and widening gaps between high and low performers. The causes are multifaceted, but many experts point to a shortage of educators trained in phonics and phonemic awareness — the foundational skills of linking the sounds of spoken English to the letters that appear on the page. The pandemic has compounded those issues."⁴

WHAT OTHER DATA DO WE NEED?

- How much does North Carolina spend per student each year?
- How does per student spending and teacher pay compare to other states?
- What factors influence teacher recruitment and retention?

WHAT COULD WORK TO TURN THE CURVE?

- Expand community and domestic violence prevention programs
- Expand statewide access to NC Pre-K, 4-, and 5-star early learning programs and other high-quality early childhood programs
- Fund statewide multisector community collaboration efforts to include children from low-income families and people of color
- Implement attendance interventions for chronically absent students
- Increase access to evidence-based parenting (including fatherhood programs), early intervention, and home visiting programs
- Increase funding and reach of Reach Out and Read programs
- Increase funding to public schools and early learning programs that serve those children with the highest barriers to success, including children from low-income families and people of color
- Invest in better data to readily identify households facing barriers to early childhood learning
- Reinforce the talent pipeline for early educators for children from birth through third grade by increasing compensation through dedicated funding, ensuring pay parity, and sustaining investments in training and professional development
- Strengthen Juvenile Crime Prevention Councils

RECOMMENDED READING/LISTENING

North Carolina Department of Public Instruction. (2021, February). *2020 Comprehensive plan for reading achievement*. K-3 Literacy Division. <https://sites.google.com/dpi.nc.gov/nck-3fap/comprehensive-plan-for-reading-achievement>

NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
Augustine Literacy Project (ALP)-Charlotte	https://alpcharlotte.org/
Book Harvest NC	https://bookharvest.org/
Dolly Parton's Imagination Library	https://imaginationlibrary.com/category/imagination-library/united-states/
NC DHHS Early Childhood Action Plan	https://www.ncdhhs.gov/about/department-initiatives/early-childhood/early-childhood-action-plan
NC DHHS North Carolina Prekindergarten Program (NC Pre-K)	https://ncchildcare.ncdhhs.gov/Home/DCDEE-Sections/North-Carolina-Pre-Kindergarten-NC-Pre-K
North Carolina Early Childhood Foundation - Pathways to Grade-Level Reading	https://buildthefoundation.org/initiative/pathways-to-grade-level-reading/
North Carolina Department of Public Instruction - Migrant Education Program	https://www.dpi.nc.gov/districts-schools/federal-program-monitoring/migrant-education
North Carolina Early Learning Network (NC-ELN)	https://nceln.fpg.unc.edu/north-carolina-early-learning-network-nc-eln
North Carolina DPI Office of Early Learning	https://www.dpi.nc.gov/districts-schools/classroom-resources/office-early-learning-oel
Peletah Academic Center for Excellence (P.A.C.E.) Ministry	https://www.peletahministries.com/pace/
Reach Out and Read	https://www.rorcarolinas.org/about-us/
Richmond County Public Schools – Child Find Campaign	https://www.richmond-county.k12.va.us/Content2/childfind#:~:text=The%20Richmond%20County%20School%20System,an%20annual%20Child%20Find%20Campaign.
The NC Partnership for Children, Inc.- Smart Start	https://www.smartstart.org/



STATE HEALTH IMPROVEMENT PLAN

HNC 2030 Indicators

PHYSICAL ENVIRONMENT FACTORS

Access to Exercise Opportunities.....	52-55
Limited Access to Healthy Foods.....	56-59
Severe Housing Problems	60-63

WHAT RESULT DO WE WANT?

All people in North Carolina have equitable and adaptive/adaptable access to physical activity opportunities across the lifespan.

WHY IS THIS IMPORTANT?

Exercise is essential for physical, social, and mental well-being. All North Carolina residents need equitable access to safe areas where they can be physically active. Equitable community environments support physical activity behaviors and provide safe exercise opportunities for the entire community. These spaces should be crime-free and accessible by public transit. They should also include safe and well-lit sidewalks, walking trails, greenways, and bike lanes.^{1,2,3}

HNC 2030 HEADLINE INDICATOR:
**Percent of people with access
to exercise opportunities**

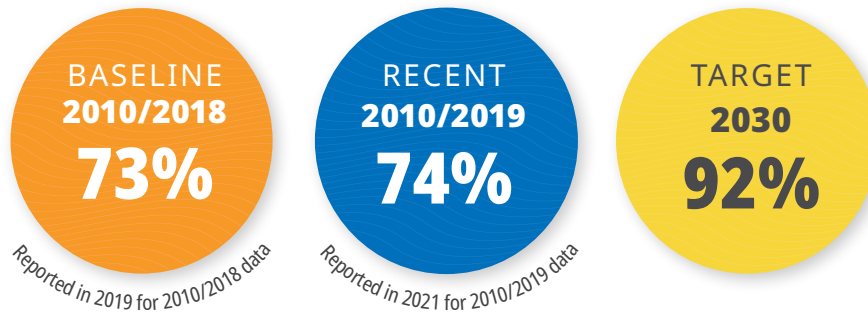
Access to safe exercise space has been highly correlated to a community's increased level of physical activity.⁴ Among adolescents, access has been shown to increase time spent in vigorous physical activity, and to lower obesity rates.⁵

Regular physical activity decreases risk for premature morbidity and mortality. Regular exercise habits have been linked to improved brain health and balance in elderly populations. It can lower risk for obesity, depression, anxiety, and dementia. Conversely, lack of physical activity can lead to serious chronic diseases, including cancer, diabetes, and heart disease. To reduce risk of chronic disease, the Centers for Disease Control and Prevention (CDC) recommends that adults engage in 150 minutes of physical exercise/physical activity per week, and children engage in a minimum of 60 minutes of physical exercise per day.^{6,7}

WHAT DOES THIS INDICATOR MEASURE?

Access to exercise opportunities measures the percentage of individuals in a county who live reasonably close to a location for physical activity. Locations for physical activity are defined as parks or recreational facilities. Individuals are considered to have access to exercise opportunities if they:

- reside in a census block that is within a half mile of a park, or
- reside in an urban census block that is within one mile of a recreational facility, or
- reside in a rural census block that is within three miles of a recreational facility.

BASELINE DATA FROM *HNC 2030*

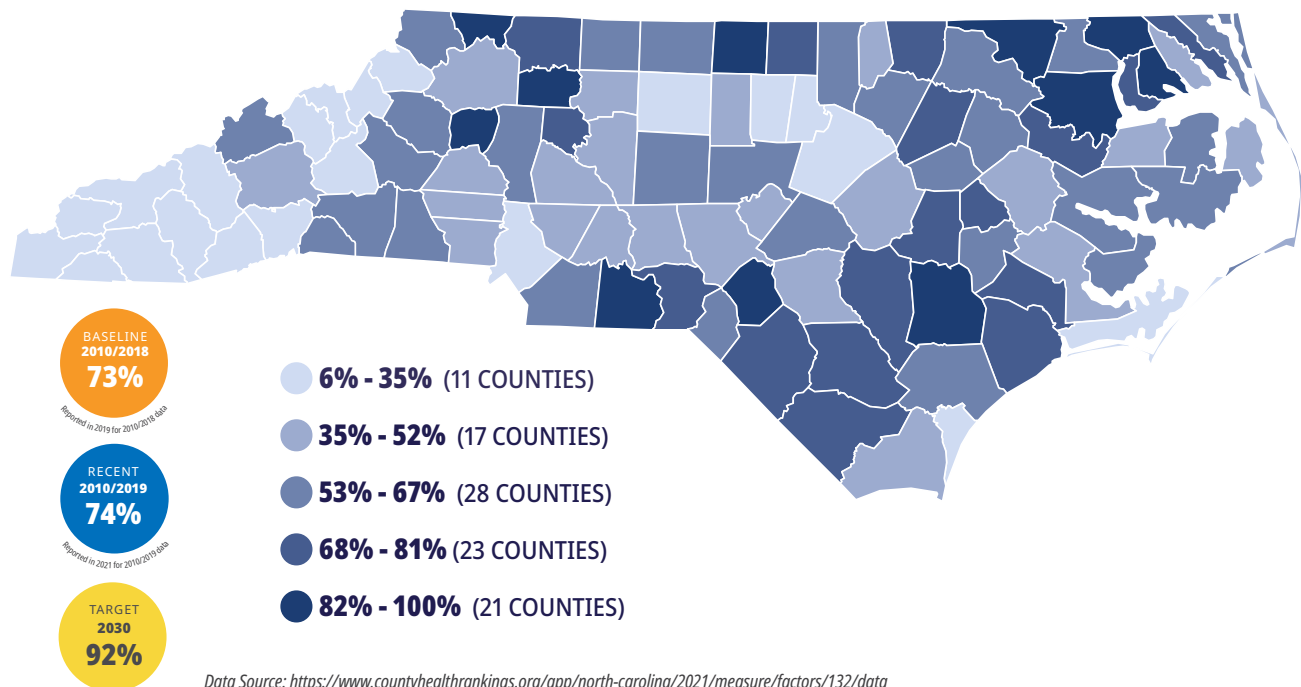
HOW ARE WE DOING?

- The *HNC 2030* target seeks to increase access to exercise opportunities from 73% to 92% by 2030.
- This measure is not appropriate for measuring progress because the data sources and definitions have changed

over time, making them incomparable. For more information see <https://www.countyhealthrankings.org/app/north-carolina/2022/measure/factors/132/description>.

CURRENT DATA TRENDED OVER TIME

Figure 34. Percent of people with access to exercise opportunities in North Carolina counties (2021)



THE STORY BEHIND THE CURVE

Multiple factors can impact individual access to exercise opportunities. These factors include income, race/ethnicity, geography, and disabilities. Low-income communities may have fewer parks recreational facilities, in contrast to more affluent communities.⁸ People of color are less likely to live near parks.⁹ Compared to metropolitan populations, residents of rural areas face additional barriers to activity opportunities.¹⁰ Finally, parks and recreational facilities may lack appropriate accommodations for individuals with physical disabilities, rendering these areas inaccessible to this population.¹¹

Dialogue from the 2022 NC State Health Improvement Plan Community Council Meeting and Symposia

- How is equity defined and how do you measure it?
- How is accessibility defined and how do you measure it? equity and access to be able to measure it?
- How is the impact of infrastructure, like walking trails, measured?
- There is grading system for community parks that has a check list and looks at who has access, is equipment ADA, are wheelchair swings available, safety and disrepair of the equipment, and timing of those that are using the park.

Policies and investment are needed to support development and expansion of community parks, transit options, sidewalk improvements, and to increase the number of greenways, walking trails and bike path.

Community partners such as childcare facilities, schools, churches, and workplaces provide essential services and infrastructure, in promoting access to physical activities. Supporting the efforts of these entities can improve access for all citizens. The COVID-19 pandemic affected physical access to facilities and interrupted the efforts of some community partnerships. Improved capabilities for partnering and providing for safe distancing will help to promote the reemergence and increased potential for robust equitable access to exercise opportunities for all.

WHAT OTHER DATA DO WE NEED?

Work with the city and/or county planning departments to identify locations in the community that are used for physical activity and select or create your own measure(s).

- Walk-ability/Bike-ability of any location - <https://www.walkscore.com/>
- How to assess your community's environment, physical activity - <https://activelivingresearch.org/toolsandresources/toolsandmeasures>

WHAT COULD WORK TO TURN THE CURVE?

- Adopt "Complete Streets" policies based on NC Department of Transportation guidelines
- Design "First and Last Mile Connections" and ADA-complaint shelters to support safe access to public transportation
- Expand transit services to increase access to places for physical activity
- Increase number of accessible community parks, particularly in rural areas
- Increase number of biking trails and lanes, walking trails, and greenways
- Increase the number of joint use/open use policy agreements for school playground facilities
- Increase opportunity for exercise for school children including active recess, physically active classrooms, school-based physical education enhancements, Walking School Buses, Safe Routes to School
- Maintain safe and well-lit sidewalks
- Promote mixed use development
- Provide public access to municipal recreation facilities
- Rethink prioritization measures for improvements, such as crash data, identification of marginalized populations, and infrastructure needs for vulnerable communities

RECOMMENDED READING/LISTENING

Williams, J. (2022). Where we work, play, and live: Health equity and the physical environment. *North Carolina Medical Journal*, 83(2), 86-89. <https://doi.org/10.18043/ncm.83.2.86>



RECOMMENDED READING/LISTENING

Williams, J. (2022). Where we work, play, and live: Health equity and the physical environment. *North Carolina Medical Journal*, 83(2), 86-89. <https://doi.org/10.18043/ncm.83.2.86>

NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
American Association of Retired Persons (AARP) Livable Communities	https://www.aarp.org/livable-communities/
Boys & Girls Clubs of North Carolina	https://www.ncclubs.org/
Boy Scouts of America-East Carolina Council	https://www.eccbsa.org/ *several councils across the state
Brenner FIT®- WakeHealth	https://www.wakehealth.edu/Specialty/b/Brenner-FIT
Bull City Fit	https://www.bullcityfit.org/
Children's Healthy Weight Research (CHWR)- UNC Center for Health Promotion and Disease Prevention	https://chwr.web.unc.edu/
Children Wellness Initiative Network (WIN) - Walk Cabarrus	https://walkcabarrus.com/our-mission/
Durham Parks & Recreation (DPR)	https://www.dprplaymore.org/
Eat Smart Move More North Carolina	https://www.eatsmartmovemorenc.com/
Girl Scouts- North Carolina Coastal Pines	https://www.nccoastalpines.org/
Go NAPSACC (Nutrition and Physical Activity Self - Assessment for Child Care)	https://gonapsacc.org/
Kids in Parks - TRACK Trails	https://www.kidsinparks.com/blog-topics/track-trails
Lumber River Council of Governments	https://www.lumberrivercog.org/
National Recreation and Park Association	https://www.nrpa.org/
NC Council of Churches	https://www.ncchurches.org/
NC State Design National Learning Initiative	https://naturalearning.org/
NC State Extension- Faithful Families	https://ncstepstohealth.ces.ncsu.edu/faithful-families/ **FF is one program
North Carolina Department of Transportation - Great Trails State Plan, Safe Routes to School Program, Let's Go NC!	<ul style="list-style-type: none"> https://www.ncdot.gov/Pages/default.aspx https://www.ncdot.gov/divisions/bike-ped/great-trails-state/Pages/default.aspx https://www.ncdot.gov/initiatives-policies/safety/safe-routes-school/Pages/default.aspx
North Carolina Recreation and Park Association (NCRPA)	https://www.ncrpa.net/
The North Carolina Partnership for Children, Inc. - Smart Start	https://www.smartstart.org/
The Trust For Public Land	https://www.tpl.org/
The Walking Classroom	https://www.thewalkingclassroom.org/
Vision Zero Network	https://visionzeronetnetwork.org/

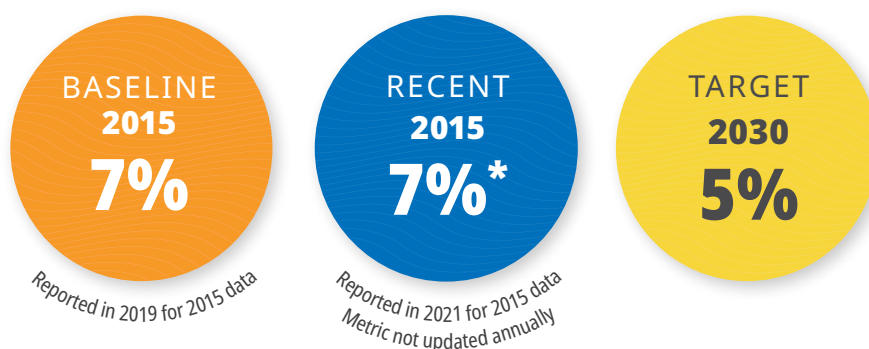
WHAT RESULT DO WE WANT?

All people in North Carolina have equitable access to affordable, nutritious, culturally appropriate foods.

WHY IS THIS IMPORTANT?

- Access to foods that support healthy eating patterns contributes to an individual's health throughout his or her life.
- Healthy eating habits include controlling calories; eating a variety of foods and beverages from all the food groups; and limiting intake of saturated and trans fats, added sugars, and sodium. Healthy eating can help lower the risk for chronic disease.
- Evidence also shows that poor nutrition and an unhealthy diet are risk factors for high blood pressure, diabetes, and cancer. According to the 2015—2020 Dietary Guidelines for Americans, healthy eating patterns include: a variety of vegetables; fruits, especially whole fruits; grains, at least half of which are whole grains; fat-free or low-fat dairy; protein foods, including seafood, lean meats and poultry, eggs, legumes (beans and peas), unsalted nuts and seeds, and soy products; and oils.
- Some research has shown that increased access to healthy foods corresponds with healthier dietary practices.

Source: Healthy People 2030¹⁻¹⁰

BASELINE DATA FROM HNC 2030**HOW ARE WE DOING?**

- The *HNC 2030* target seeks to decrease limited access to healthy foods from 7% to 5% by 2030.
- County Health Rankings & Roadmaps discontinued this metric in 2020 making it not appropriate for measuring progress.
- The food environment index replaces the limited access to healthy foods metric. (<https://www.countyhealthrankings.org/app/north-carolina/2021/measure/factors/133/data>).

HNC 2030 HEADLINE INDICATOR:**Percent of people with limited access to healthy foods**

The data are derived from the 2015 US Department of Agriculture and was reported in the Robert Wood Johnson County Health Rankings (CHR). This measure is no longer ranked at CHR and has been replaced by a composite measure of the food environment which includes food insecurity and access to healthy foods.

WHAT DOES THIS INDICATOR MEASURE?

Consider alternative indicator: Food Environment Index - Proximity to healthy foods and income

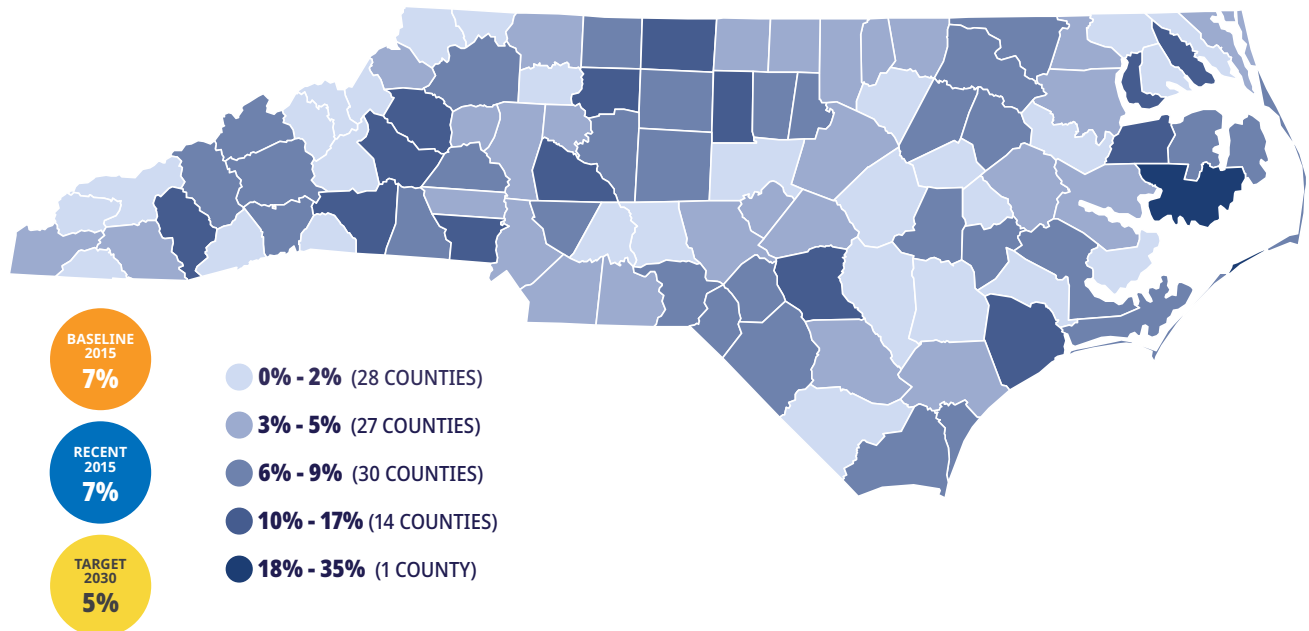
<https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/health-behaviors/diet-exercise/food-environment-index>

<https://www.countyhealthrankings.org/app/north-carolina/2021/measure/factors/133/data>

- Limited Access to Healthy Foods (2015 data)
- Food Insecurity (2018 data)

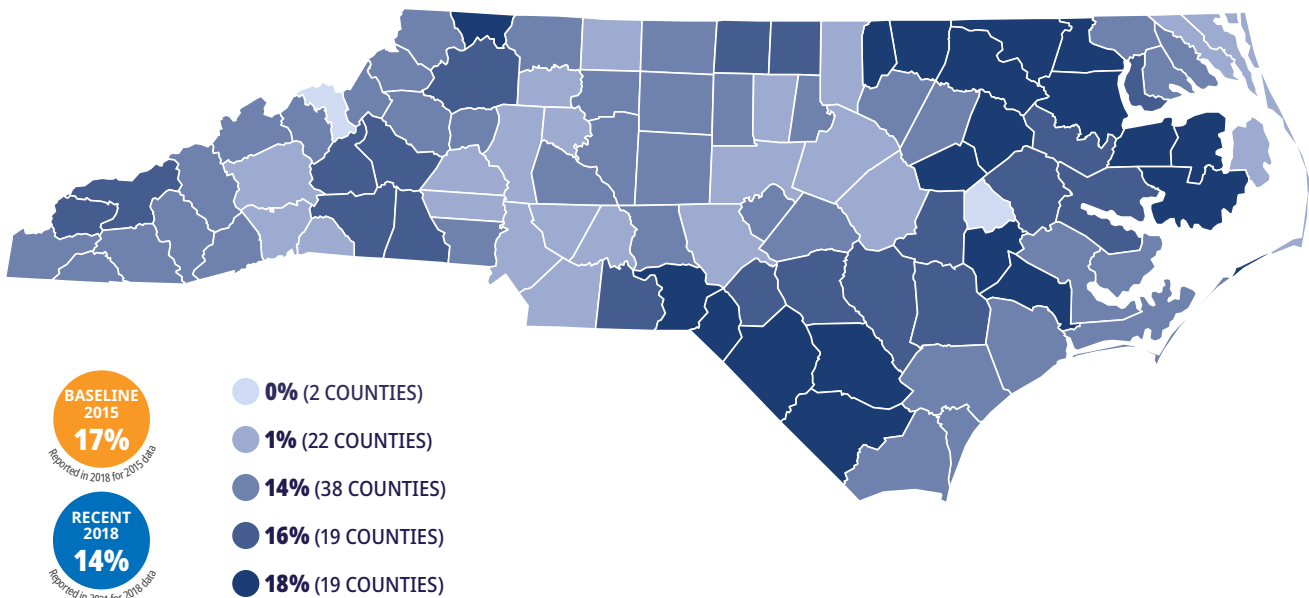
CURRENT DATA TRENDED OVER TIME

Figure 35. Percent of people with limited access to healthy foods (2021)



Data Source: <https://www.countyhealthrankings.org/app/north-carolina/2021/measure/factors/133/data>

Figure 36. Percent of people with food insecurity (2021)



Data Source: <https://www.countyhealthrankings.org/app/north-carolina/2021/measure/factors/133/data>

THE STORY BEHIND THE CURVE

- There are barriers to, and disparities in, the accessibility and availability of foods that support healthy eating patterns. Data from 2012—2013 show that the average distance from U.S. households to the nearest supermarket was 2.19 miles. Individuals without a vehicle or access to convenient public transportation, or who do not have food venues with healthy choices within walking distance, have limited access to foods that support healthy eating patterns.
- Transportation and distance to sources of healthy foods impact low-income and rural communities, especially older adults living in rural communities. Overall, for those who do not have access to a car or public transportation, the cost of travel time to find healthier options in addition to out-of-pocket expenses may be too high.
- Another barrier to accessibility of healthy food choices is living in a food desert. In food deserts, food sources are lacking or limited, particularly in low-income areas that are more also likely to have a higher share of convenience stores and small food markets. These options tend to carry foods of lower nutritional quality compared to large chain supermarkets, which may have a wider variety of healthy options.
- Improving access to foods that support healthy eating patterns is one method for addressing health disparities and population health. Several strategies that aim to “improve diet by altering food environments” are being considered and implemented.
- For example, a study has shown that a small financial incentive increased the use of Supplemental Nutrition Assistance Program (SNAP) benefits in participating farmers markets – resulting in increased access to healthy foods.
- Several strategies have also been proposed to encourage more equitable access to healthy food choices, such as, “attracting and opening supermarkets in underserved neighborhoods, selling healthy foods at reduced prices, and limiting the total number of per capita fast-food restaurants in a community.”

Source: Healthy People 2030 11-20

WHAT OTHER DATA DO WE NEED?

- Access to locally grown food
- Availability of public transportation
- Individuals over 65 who are living below the poverty level
- Number/percentage of children receiving free/reduced school meals
- Percentage of people unemployed
- Referrals for food assistance through NCCARE360

WHAT COULD WORK TO TURN THE CURVE?

- Continue, expand, and institutionalize the Supplemental Nutrition Assistance Program (SNAP) online purchasing pilot
- Enhance how children and families access programs supporting their well-being, including SNAP, WIC, CACFP, Medicaid, NCCARE360 through better data and analysis, infrastructure, and integration
- Establish a public-private fund for stimulating the development/renovation/expansion of new and existing community-supported venues
- Expand transit options in rural and low-income communities
- Implement competitive pricing for healthy foods
- Implement healthy food procurement and food served policies in public and private organizations and businesses
- Implement school breakfast programs and school fruit and vegetable gardens
- Include healthy foods in convenience stores and food pantries
- Provide additional funding and support to School Nutrition Programs to expand healthy, locally sourced food options and reduce financial barriers for students
- Provide financial incentives such as “Double Up Food Bucks” for SNAP/FNS recipients for purchasing fresh fruit and vegetables from grocery stores and farmers markets
- Support equitable, food-oriented development that drives economic growth in low-income and historically marginalized communities
- Support farmers’ efforts to maintain active crop production in areas with high land prices
- Support farmers’ markets and enable Electronic Benefit Transfer payment at farmers’ markets
- Support regional food hubs in adopting solid business models, with built-in reliance on subject matter experts



RECOMMENDED READING/LISTENING

Casey, A., Pylypiw, N. (2022). Running the numbers: Measuring food hardship in North Carolina communities. *North Carolina Medical Journal*, 83(2), 126–129. <https://doi.org/10.18043/ncm.83.2.126>

Phillips, K.U. (2022). Achieving Healthy NC 2030 goals: Physical environment. *North Carolina Medical Journal*, 83(2), 121-123. <https://doi.org/10.18043/ncm.83.2.121>

North Carolina Healthy Food Retail Task Force. (2019). Supporting Healthy Food Access in North Carolina. Retrieved on March 2, 2022 from ncreportfinal.original.pdf (thefoodtrust.org)

NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
American Heart Association	https://www.heart.org/en/healthy-living/healthy-eating/fighting-food-insecurity
BlueCross BlueShield of North Carolina Foundation	https://www.bcbsncfoundation.org/
Carteret Local Food Network (CLFN)	https://www.carteretlocalfoodnetwork.org/
Center for Environmental Farming Systems	https://cefs.ncsu.edu/food-system-initiatives/local-food-economies/infrastructure-map/
Child and Adult Care Food Program (CACFP)	https://www.fns.usda.gov/cacfp
Community Food Strategies	https://communityfoodstrategies.org/
Communities In Partnership	https://communitiesinpartnership.org/
Duke Sanford World Food Policy Center	https://wfpc.sanford.duke.edu/research
Durham's Innovative Nutrition Education (DINE)- North Carolina State Supplemental Nutrition Assistance Program Education (SNAP-Ed)	https://snaped.fns.usda.gov/state-snap-ed-programs/north-carolina https://www.dcopublichealth.org/services/nutrition/dine
Farmers' Market Nutrition Program (FMNP)	https://www.nutritionnc.com/wic/fmarket.htm
Feast Down East	https://www.feastdowneast.org/
Feeding the Carolinas	https://feedingthecarolinas.org/
Green Rural Redevelopment Organization (GRRO)	https://www.conservationfund.org/projects/green-rural-redevelopment-organization
Guilford College Mobile Oasis Farmers Market	https://guilfordmobileoasis.com/
Inter-Faith Food Shuttle	https://www.foodshuttle.org/
Meals on Wheels North Carolina	https://www.mealsonwheelsamerica.org/about-membership/state-associations/north-carolina
NC Council of Churches	https://www.ncchurches.org/
NC State Cooperative Extension	https://www.ces.ncsu.edu/categories/agriculture-food/local-foods/
NC State University Institute for Emerging Issues	https://iei.ncsu.edu/
North Carolina Alliance for Health (NCAH)	https://www.ncallianceforhealth.org/healthy-food-access/
North Carolina Department of Agriculture & Consumer Services	http://www.ncagr.gov/
North Carolina Local Food Council (NCLFC)	https://www.nclocalfoodcouncil.org/
Reinvestment Partners	https://reinvestmentpartners.org/
Senior Farmer's Market Nutrition Program (SFMNP)- USDA Food and Nutrition Service	https://www.fns.usda.gov/sfmnp/senior-farmers-market-nutrition-program
The Corner Farmers Market/The Grove Street People's Market Green for Greens Fund	https://green4greens.org/markets/
The Food Bank of Central & Eastern North Carolina	https://foodbankcenc.org/
UNC Center for Health Promotion and Disease Prevention	https://hpd.unc.edu/research/healthy-food-access/

WHAT RESULT DO WE WANT?

All people in North Carolina have safe, affordable, quality housing opportunities.

WHY IS THIS IMPORTANT?

- Housing instability encompasses several challenges, such as having trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household income on housing. These experiences may negatively affect physical health and make it harder to access health care.
- Households are cost burdened if they spend more than 30% of their income on housing and severely cost burdened if they spend more than 50% of their income on housing. Cost-burdened households have little left over each month to spend on other necessities such as food, clothing, utilities, and health care. Black and Hispanic households are almost twice as likely as white households to be cost burdened.

HNC 2030 HEADLINE INDICATOR:
Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities

Source: Healthy People 2030 ¹⁻⁷

WHAT DOES THIS INDICATOR MEASURE?

Indicates how many of us live in housing that we cannot afford, that may be overcrowded, and even have serious problems with kitchen and bathrooms

- The indicator is reported in the Robert Wood Johnson County Health Rankings (CHR)
- Composite measure of four housing problems
- Data are three years old when presented
- Does not include “non-severe” housing problems that could have a significant impact on health

BASELINE DATA FROM HNC 2030

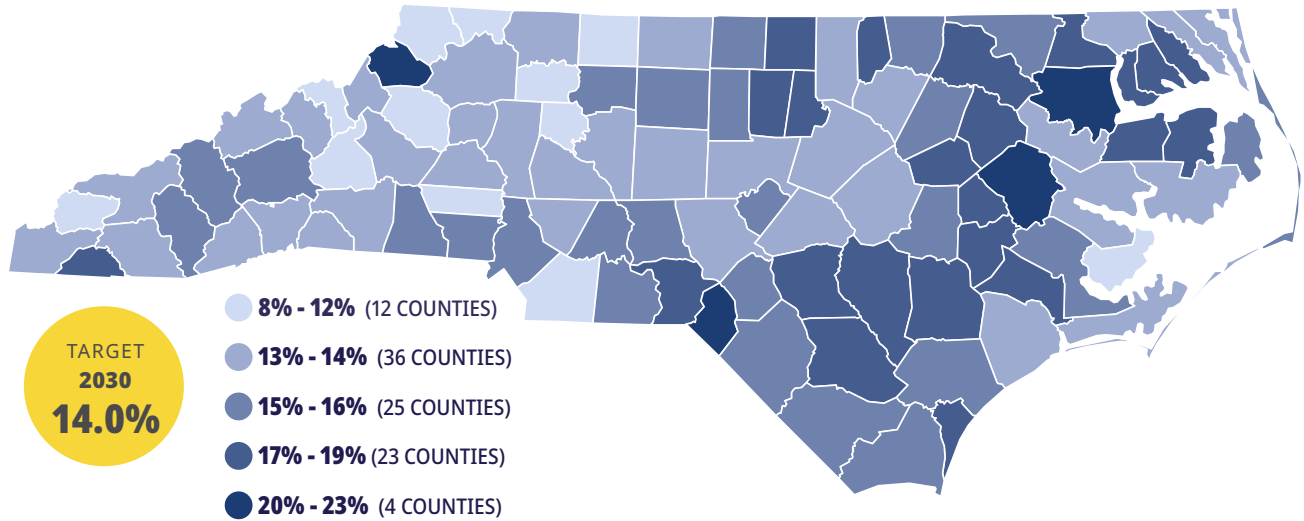


HOW ARE WE DOING?

- The HNC 2030 target seeks to decrease the percentage of North Carolina households with severe housing problems from 16.1% to 14.0% by 2030.
- Approximately half of North Carolina's counties exceed the HNC 2030 target of 14.0% households affected by high housing costs.

CURRENT DATA TRENDED OVER TIME

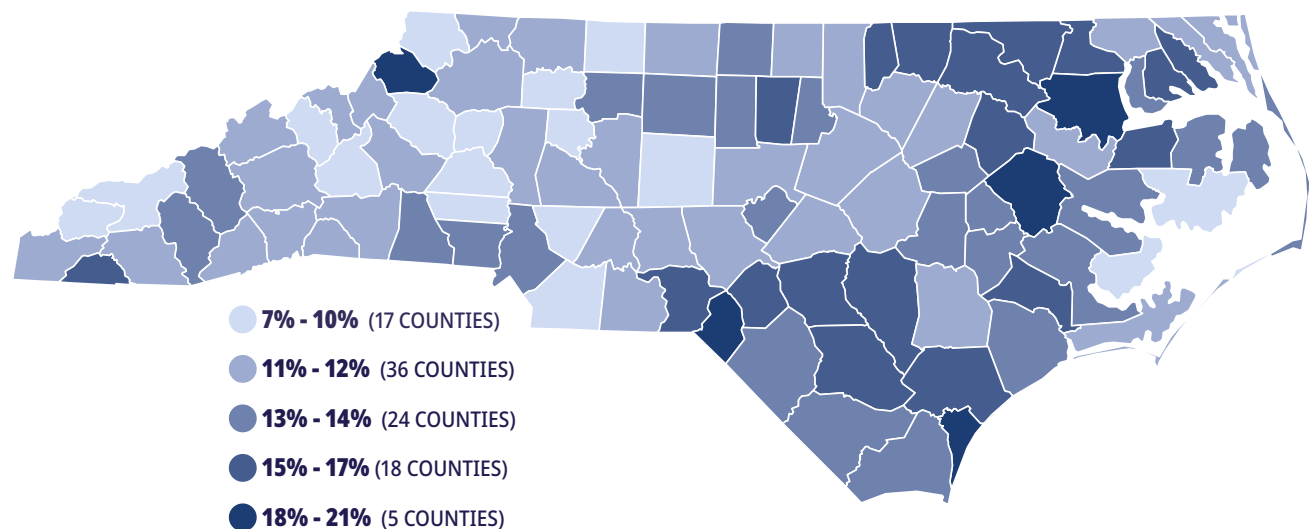
Figure 37. Percent of households with severe housing problems in North Carolina counties, 2021*



*Five-year average based upon 2013-2017 data and reported in the 2021 County Health Rankings & Roadmaps.

Data source: The U.S. Department of Housing and Urban Development (HUD), U.S. Census Bureau to produce the Comprehensive Housing Affordability Strategy (CHAS) data sets.

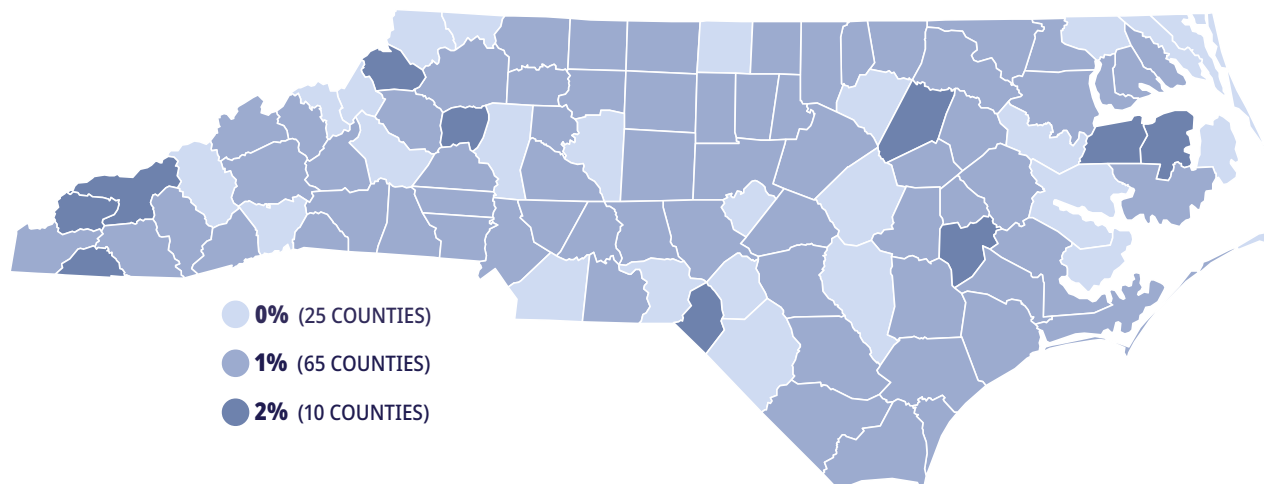
Figure 38. Percent of households with high housing costs in North Carolina counties, 2021*



*Five-year average based upon 2013-2017 data and reported in the 2021 County Health Rankings & Roadmaps.

Data source: The U.S. Department of Housing and Urban Development (HUD), U.S. Census Bureau to produce the Comprehensive Housing Affordability Strategy (CHAS) data sets.

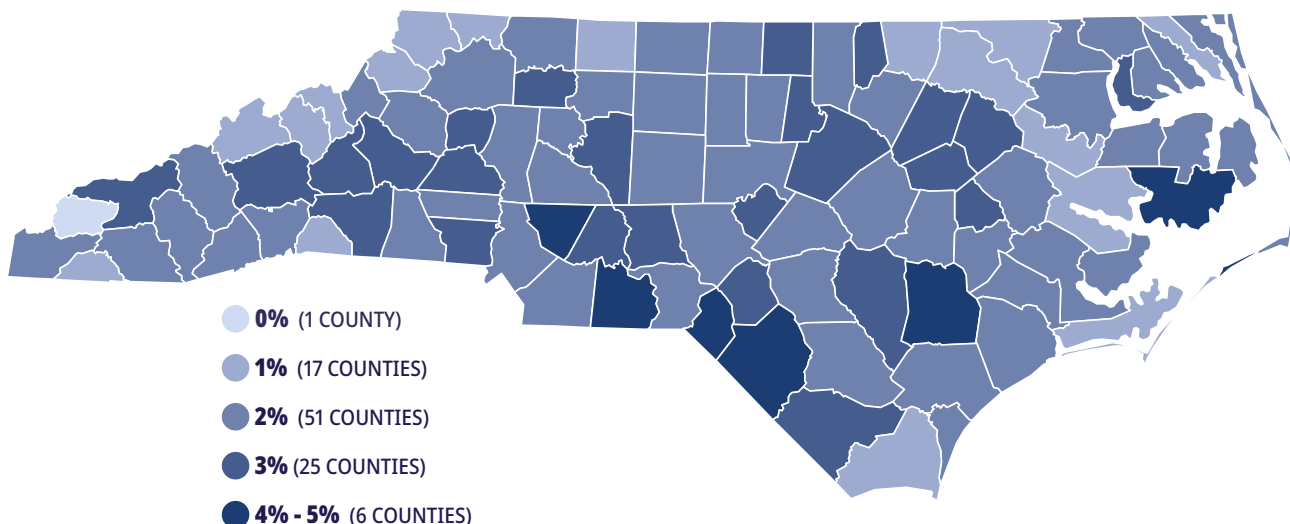
Figure 39. Percent of households with inadequate kitchen and/or bathroom facilities in North Carolina counties, 2021*



*Five-year average based upon 2013-2017 data and reported in the 2021 County Health Rankings & Roadmaps.

Data source: The U.S. Department of Housing and Urban Development (HUD), U.S. Census Bureau to produce the Comprehensive Housing Affordability Strategy (CHAD) data sets.

Figure 40. Percent of households with overcrowding in North Carolina counties, 2021*



*Five-year average based upon 2013-2017 data and reported in the 2021 County Health Rankings & Roadmaps.

Data source: The U.S. Department of Housing and Urban Development (HUD), U.S. Census Bureau to produce the Comprehensive Housing Affordability Strategy (CHAD) data sets.

THE STORY BEHIND THE CURVE

- Housing quality refers to the physical condition of a person's home as well as the quality of the social and physical environment in which the home is located. Aspects of housing quality include air quality, home safety, space per individual, and the presence of mold, asbestos, or lead.
- Housing quality is affected by factors like a home's design and age.
- Poor-quality housing is associated with various negative health outcomes, including chronic disease and injury and poor mental health.
- The quality of a home's neighborhood is shaped in part by how well individual homes are maintained, and widespread residential deterioration in a neighborhood can negatively affect mental health.
- Both home design and structure significantly influence housing quality and may affect mental and physical health.
- Steps, balconies, and windows are features of home design that may present a threat to safety, especially for individuals with physical disabilities. Breakable glass, low windowsills, and poorly constructed stairs may increase the risk of injury from a fall.

Source: Healthy People 2030 8-17

WHAT OTHER DATA DO WE NEED?

DHHS, in partnership with a diverse set of stakeholders, developed a standardized set of Social Determinants of Health screening questions to address and acquire data on the following:

- Food insecurity
- Housing instability
- Lack of transportation
- Interpersonal violence

<https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions>

WHAT COULD WORK TO TURN THE CURVE?

- Consider regulatory change allowing mobile homes to be registered as real property (homes), not as personal property (vehicles)
- Enforce fair housing laws and create affordable housing legislation
- Expand housing support services that implement a housing first model and accept people with substance use disorders or persistent mental illness
- Expand rapid re-housing programs to transition families and individuals experiencing homelessness into permanent housing quickly, often with supports such as short-term financial assistance, case management, landlord negotiations, etc.
- Implement “right to counsel” measures to provide tenants with access to legal representation when facing landlords in court
- Institute community land trusts in which the community purchases the land a home is on to lease to homeowners with low and middle incomes and require homeowners to sell the home back to the trust or to another resident with low income upon moving
- Promote Weatherization Assistance Program and Low-Income Home Energy Assistance Programs to provide assistance to families with low income to meet energy needs
- Support people with disabilities to live their lives as fully included members of the community by engaging in an inclusive process to develop and implement an updated strategic Olmstead plan
- Support programs designed to increase home ownership for people of color
- Update housing standards for agriculture workplace housing (H2A housing), as regulated by the federal Occupational Safety and Health Administration
- Update the Migrant Housing Act of North Carolina to promote safe and healthy home environments for migrant workers

RECOMMENDED READING/LISTENING

Sills, Stephen J. The Status and Impact of Severe Housing Problems and Evictions in North Carolina. (March 2022)
<https://www.ncmedicaljournal.com/content/83/2/94>

NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
CASA (Court Appointed Special Advocates)	https://www.casanc.org/
Crisis Assistance Ministry	https://www.crisisassistance.org/
Episcopal Farmworker Ministry	https://episcopalfarmworkerministry.org/
Habitat for Humanity of North Carolina	https://habitatnc.org/
Legal Aid of North Carolina	https://www.legalaidnc.org/
NC DHHS Housing and Home Improvement Assistance	https://www.ncdhhs.gov/assistance/low-income-services/housing-home-improvement-assistance
Neighborhood Assistance Corporation of America	https://www.naca.com/
North Carolina Housing Coalition	https://nchousing.org/
North Carolina Housing Finance Agency	https://www.nchfa.com/
North Carolina Voluntary Organizations Active in Disaster- Long-Term Recovery Groups (LTRGs) & Community Organizations in Active Disaster (COADs)	https://www.ncvoad.org/coads-ltrgs/
Reinvestment Partners-Hotel to Home	https://reinvestmentpartners.org/ https://reinvestmentpartners.org/what-we-do/hotel-to-home.html
Center for Public Engagement with Science	https://ie.unc.edu/cpes/ and https://nchealthyhomes.com/
UNC-Greensboro Center for Housing and Community Studies	https://chcs.uncg.edu/
UNC Institute for the Environment	https://ie.unc.edu/



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STATE HEALTH IMPROVEMENT PLAN

HNC 2030 Indicators

HEALTH BEHAVIORS

Drug Overdose Deaths.....	66-69
Tobacco Use.....	70-75
Excessive Drinking.....	76-78
Sugar-Sweetened Beverage Consumption.....	80-83
HIV Diagnosis	84-89
Teen Birth.....	90-92

WHAT RESULT DO WE WANT?

All individuals and families in North Carolina with substance use disorder receive person-centered care incorporating evidence-based behavioral and pharmacological approaches.

WHY IS THIS IMPORTANT?

An average of nine North Carolinians died each day from a drug overdose in 2020, a 40% increase from the previous year. This stark increase during 2020 aligns with the increases experienced nationwide with the nation exceeding 100,000 deaths. In North Carolina, the number of drug overdose deaths — from illicit substances and/or medications — increased by nearly 1,000 deaths, from 2,352 in 2019 to 3,304 in 2020. There were also nearly 15,000 emergency department visits related to drug overdoses in 2020. Provisional surveillance data suggest these increases continued through 2021. Both overdose deaths and the increases disproportionately affect historically marginalized populations.¹

HNC 2030 HEADLINE INDICATOR:

Drug overdose deaths in North Carolina per 100,000 population, age-adjusted

WHAT DOES THIS INDICATOR MEASURE?

- Number of people who die because of drug poisoning per 100,000 population (age-adjusted to 2000 standard population)
- The data are disaggregated by race/ethnicity, county, and gender

Drug categories included:

- heroin
- natural opioid analgesics, including morphine and codeine and semisynthetic opioids, including drugs such as oxycodone, hydrocodone, hydromorphone, and oxymorphone
- methadone, a synthetic opioid
- synthetic opioid analgesics other than methadone, including drugs such as fentanyl and tramadol
- cocaine
- psychostimulants with abuse potential, which includes methamphetamine.

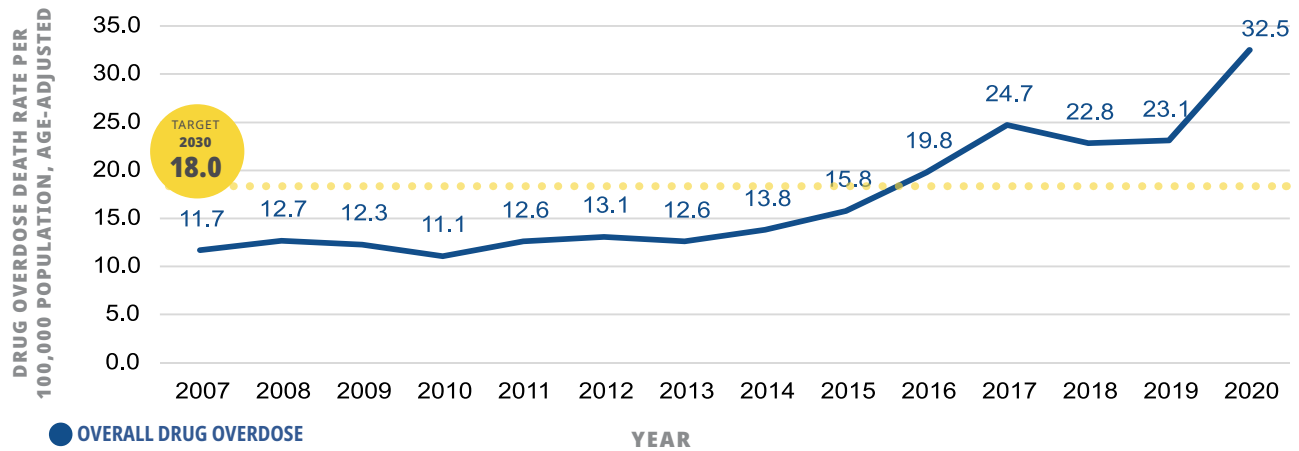
Drug overdose deaths involve medical examiners whose cases can be delayed while cause of death determinations await toxicology reports before they can be completed. Small numbers in subgroups can make rates unstable and may necessitate the combining of years.

BASELINE DATA FROM HNC 2030**HOW ARE WE DOING?**

- Drug overdose death rates have doubled since 2015, with American Indian/Alaskan Native group experiencing the highest rate increase.
- Drug overdose death rates continue increasing for both males and females, but the rate of increase is higher for males.

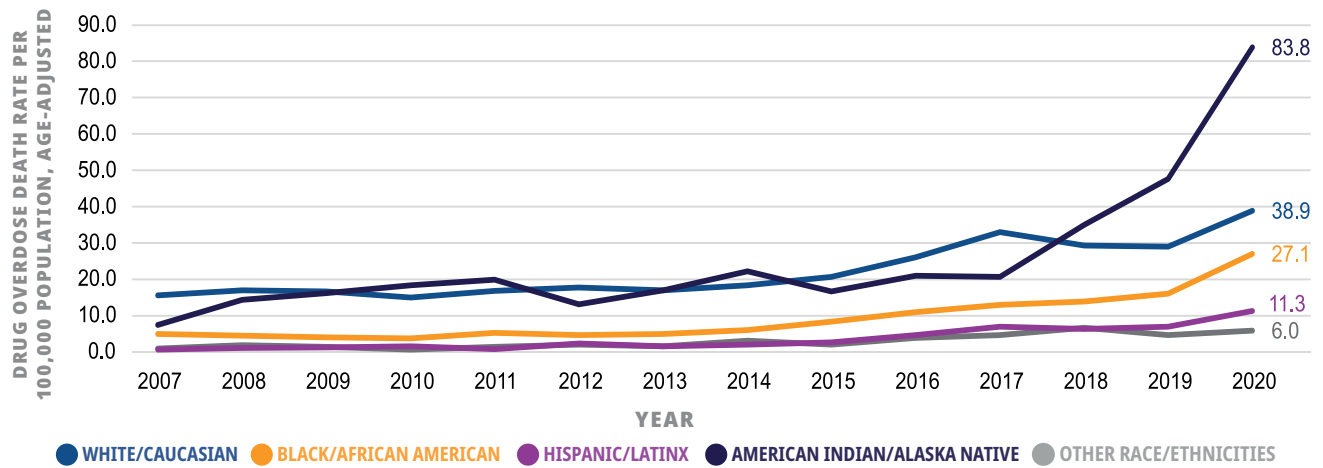
CURRENT DATA TRENDED OVER TIME

Figure 41. Drug overdose death rate in North Carolina (2007 - 2020)



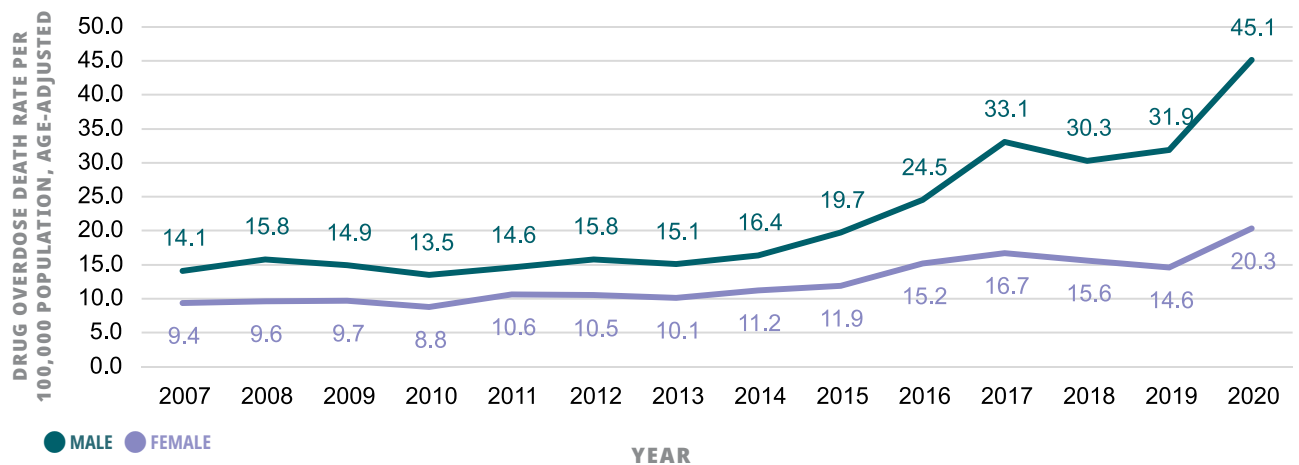
Data source: N.C. State Center for Health Statistics, Vital Statistics

Figure 42. Drug overdose death rate in North Carolina by race/ethnicity (2007 - 2020)



Note: Data unavailable for Asian/Pacific Islanders. Data source: N.C. State Center for Health Statistics, Vital Statistics

Figure 43. Drug overdose death rate in North Carolina by gender (2007 - 2020)



Data source: N.C. State Center for Health Statistics, Vital Statistics

THE STORY BEHIND THE CURVE

Prescription medications have been a major driver of the opioid epidemic, but illicit drugs (heroin and synthetic fentanyl) are also increasingly contributing to this problem. Additionally, North Carolina and many other states are identifying fentanyl and opioid analogues in other kinds of illicit drugs (including cocaine, methamphetamine and counterfeit pills). People using these substances may unknowingly be exposed to opioids and are at high risk of opioid overdose. Using harm reduction techniques for safer use and having naloxone on-hand can help prevent fatal opioid overdose.²

WHAT OTHER DATA DO WE NEED?

- Substance use disorder and unemployment are closely related. Unemployment data is needed
- Statewide overdose dashboard-definitions should match/be consistent to avoid confusion
- Emergency department visits for substance use disorder
- Emergency medical service calls for substance use disorder
- Availability of sterile syringes, naloxone, and buprenorphine
- Deaths and emergency department visits

WHAT COULD WORK TO TURN THE CURVE?

- Advocate for comprehensive resource repositories, such as 211 or NCCARE360
- Encourage insurance companies to expand access to treatment and recovery services by piloting alternative pain management models
- Expand housing support services that implement a housing first model and accept people with substance use disorders
- Expand Medicaid eligibility
- Expand peer support specialist programs
- Expand rapid access to crisis services, including implementing the national 988 number
- Implement broader use of NC Controlled Substance Reporting System by health care providers and pharmacies
- Implement “Formerly Incarcerated Transition” programs
- Improve access to drug treatment programs, including medication-assisted treatment
- Increase access to care for justice-involved populations who have behavioral health needs by diverting more people away from incarceration and into treatment, adding more jail-based “medication assisted treatment” programs, and restoring individuals’ capacity in jail- and community-based settings
- Increase distribution of naloxone
- Increase the use of agonist therapies (methadone and buprenorphine)
- Increase training for county commissioners on evidence-based practices for substance use disorder
- Increase training for health care providers on buprenorphine prescribing
- Increase training for health care providers on safe prescribing practices
- Invest in care management and connections to treatment for families with substance use disorders who are involved with the Child Welfare System
- Invest in long-term support for syringe service programs, and expand their ability to increase drug checking to prevent overdoses from contamination
- Support policies that decriminalize and promote treatment of substance use disorder
- Support the cost of treatment, safe recovery housing, and prescriptions



RECOMMENDED READING/LISTENING

Essential Actions to Address the Opioid Epidemic: A Local Health Department's Guide.
<https://www.ncdhhs.gov/about/departments-initiatives/opioid-epidemic/nc-essential-actions-address-opioid-epidemic-local>

North Carolina Opioid Settlement Dashboard.
<https://ncopioidsettlement.org/>

Opioid Action Plan 3.0.
 North Carolina Department of Health and Human Services. (2021, May). North Carolina's opioid and substance use action plan, version 3.0.
<https://www.ncdhhs.gov/about/departments-initiatives/overdose-epidemic/north-carolinas-opioid-and-substance-use-action-plan>

NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
Monarch	https://monarchnc.org/services/
NC Council of Churches	https://www.ncchurches.org/programs/phw/opioid-crisis/
NC DHHS North Carolina Opioid and Prescription Drug Abuse Advisory Committee (OPDAAC)	https://www.ncdhhs.gov/about/departments-initiatives/overdose-epidemic/nc-opioid-and-prescription-drug-abuse-advisory-committee
NC DHHS North Carolina Treatment Accountability for Safer Communities (NC TASC)	https://www.ncdhhs.gov/assistance/mental-health-substance-abuse/treatment-accountability-for-safer-communities
North Carolina Area Health Education Centers (NC AHEC)	https://www.ncahec.net/healthy-north-carolina-2030/
North Carolina Harm Reduction Coalition (NCHRC)	https://www.nchrc.org/programs/overdose-prevention/
North Carolina's Certified Peer Support Specialist Program	https://pss.unc.edu/
North Carolina Department of Insurance Office of State Fire Marshal (NC OSFM)- Safe Kids NC	https://www.ncosfm.gov/community-risk-reduction/safe-kids/safe-kids-nc-information
North Carolina Medical Board	https://www.ncmedboard.org/resources-information/professional-resources/special-topics
North Carolina Treatment Accountability for Safer Communities (NC TASC)	https://www.ncdhhs.gov/assistance/mental-health-substance-abuse/treatment-accountability-for-safer-communities
Opioid Response Network (ORN)- funded by the Substance Abuse and Mental Health Services Administration (SAMHSA)	https://opioidresponsenetwork.org/
Recovery Communities of North Carolina	https://www.rcnc.org/programs-services/
Stop the Addiction Fatality Epidemic (SAFE) Project	https://www.safeproject.us/
UNC Injury Prevention Research Center (IPRC)	https://iprc.unc.edu/research/opioid-disorder-overdose/

WHAT RESULT DO WE WANT?

All people in North Carolina live in communities that support tobacco-free/e-cigarette-free lifestyles.

WHY IS THIS IMPORTANT?

Smoking kills more people than alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined — and thousands more die from other tobacco-related causes such as involuntary exposure to secondhand smoke, fires caused by smoking (more than 1,000 deaths/year nationwide) and smokeless tobacco use.¹

HNC 2030 HEADLINE INDICATOR:

Percent of youth and adults reporting current use of e-cigarettes, cigarettes, cigars, smokeless tobacco, pipes, and/or hookah

WHAT DOES THIS INDICATOR MEASURE?

- Percent of Tobacco Use Across the Population: Percent of Adults Reporting Current Use of E-Cigarettes, Cigarettes, Cigars, Smokeless Tobacco, Pipes, and/or Hookah

SMOKELESS TOBACCO

- Question: "Do you currently use chewing tobacco, snuff, or snus every day, some days, or not at all?"
- Respondents who answer "every day" or "some days" are considered current users.

CIGARS

- Question: "During the past 30 days, did you smoke cigars, cigarillos, or little cigars?"
- Respondents who answer "every day" or "some days" are considered current users.

HOOKAH

- Question: "During the past 30 days, have you used a hookah or water pipe?" Respondents who answer "every day" or "some days" are considered current users.

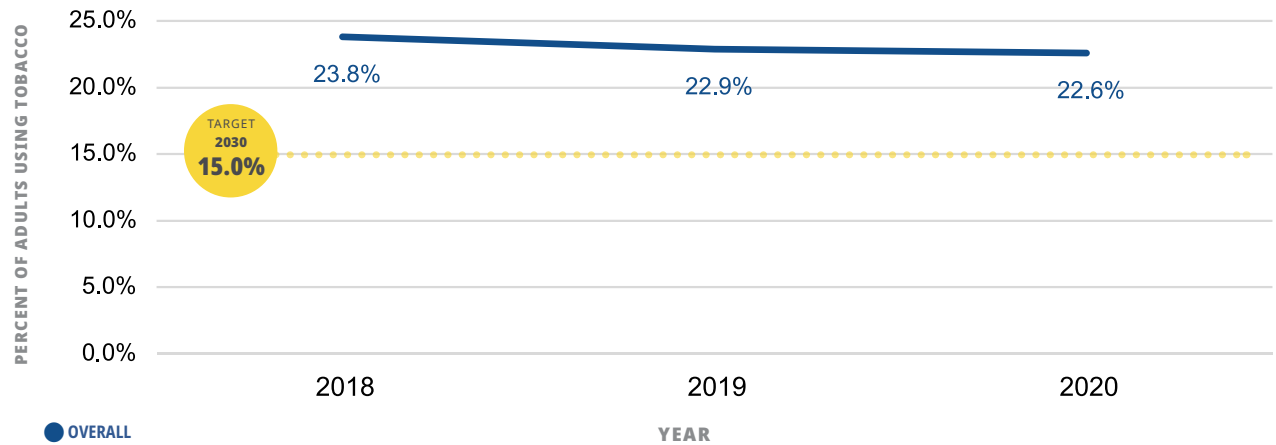
- The number of noninstitutionalized adults who use one or more of these tobacco products daily or on some days.
- Beginning in 2021, data are reported annually by sex, race/ethnicity, and age.
- Estimates are reported for the state, three broad geographic regions, AHECs, Medicaid regions, and Local Health Director regions.

BASELINE DATA FROM HNC 2030**HOW ARE WE DOING?**

- Tobacco product use (including e-cigarettes) among adults has been relatively steady since 2018.
- Among adults, males have greater reported use of any tobacco product than females.
- Among various race/ethnicities, White/Caucasian use of tobacco products remains high at 24.4% in 2020.
- Reported tobacco product use among high school students remains relatively steady at 27.3% in 2019.
- Reported tobacco use among middle school students saw a slight decline from 11.6% in 2015 to 10.4% in 2019.

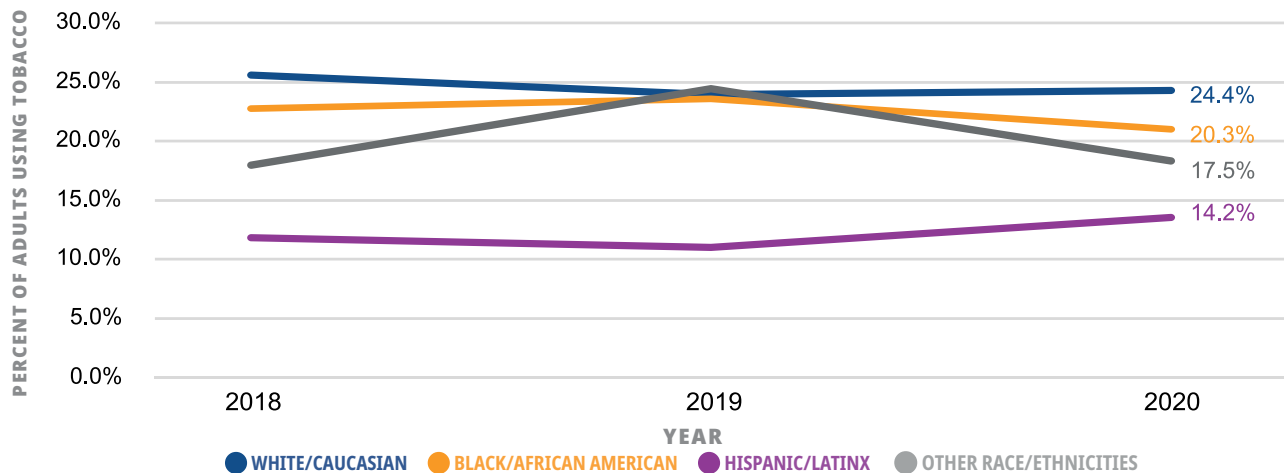
CURRENT DATA TRENDED OVER TIME

Figure 44. Tobacco use among adults in North Carolina (2018 - 2020)



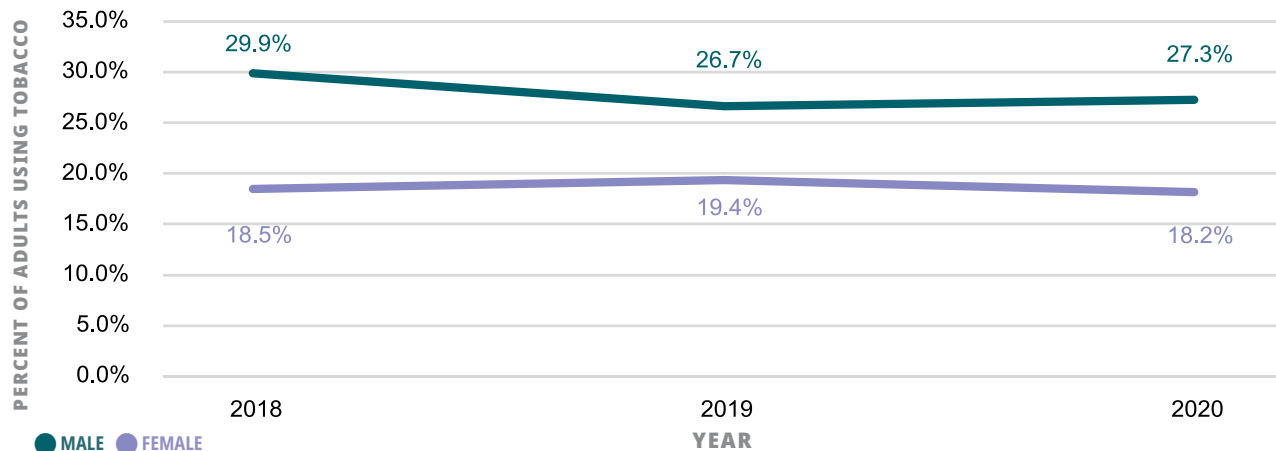
Data source: Behavioral Risk Factor Surveillance System (BRFSS), N.C. State Center for Health Statistics

Figure 45. Tobacco use among adults in North Carolina by race/ethnicity (2018 - 2020)



Data source: Behavioral Risk Factor Surveillance System (BRFSS), N.C. State Center for Health Statistics

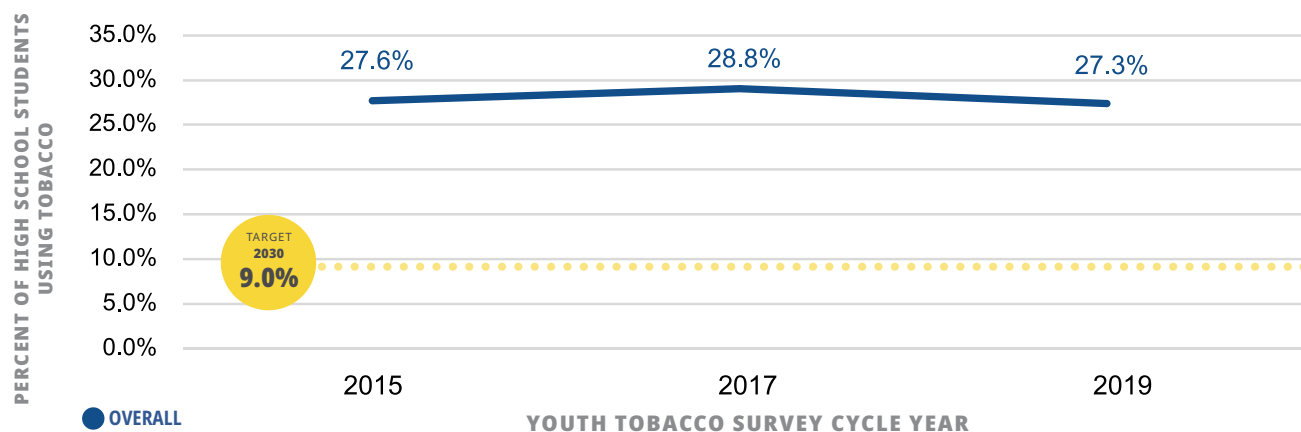
Figure 46. Tobacco use among adults in North Carolina by gender (2018 - 2020)



Data source: Behavioral Risk Factor Surveillance System (BRFSS), N.C. State Center for Health Statistics

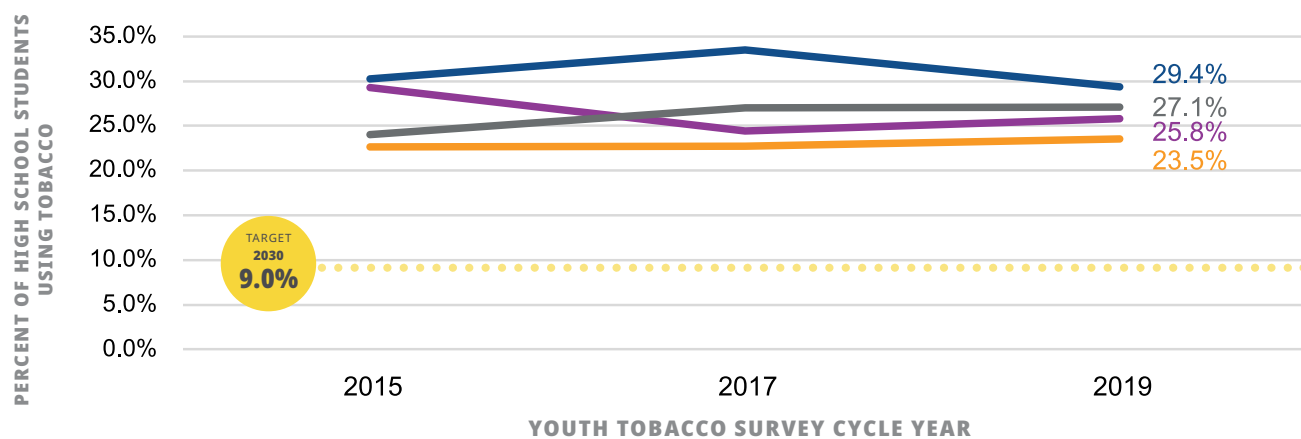
TOBACCO USE

Figure 47. Tobacco use among high school students in North Carolina (2015 - 2019)



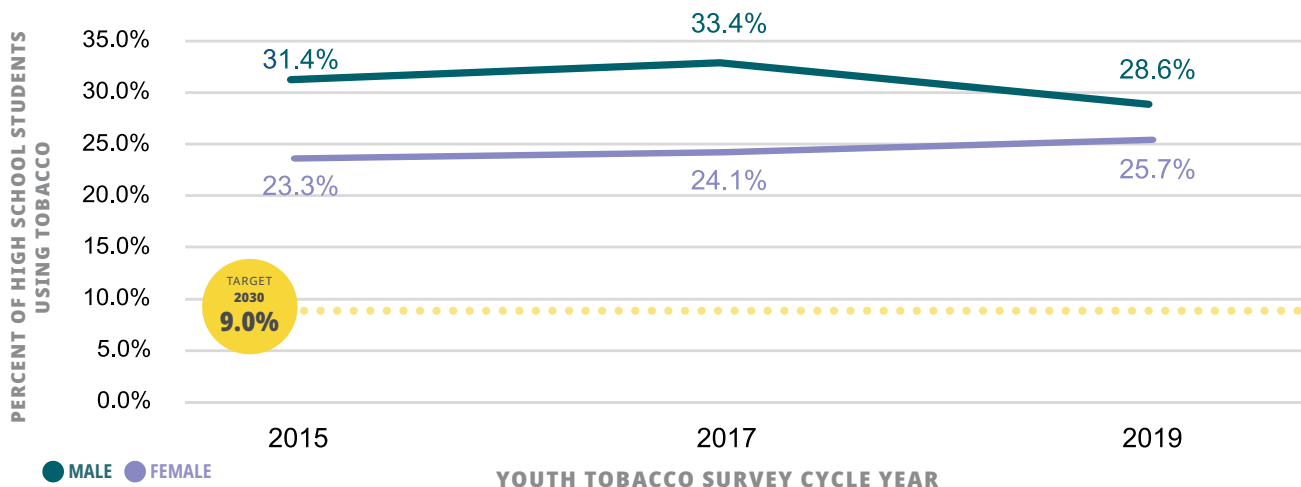
Data source: N.C. Youth Tobacco Survey

Figure 48. Tobacco use among high school students in North Carolina by race/ethnicity (2015 - 2019)



Data source: N.C. Youth Tobacco Survey

Figure 49. Tobacco use among high school students in North Carolina by gender (2015 - 2019)



Data source: N.C. Youth Tobacco Survey

Figure 50. Tobacco use among middle school students in North Carolina (2015 - 2019)

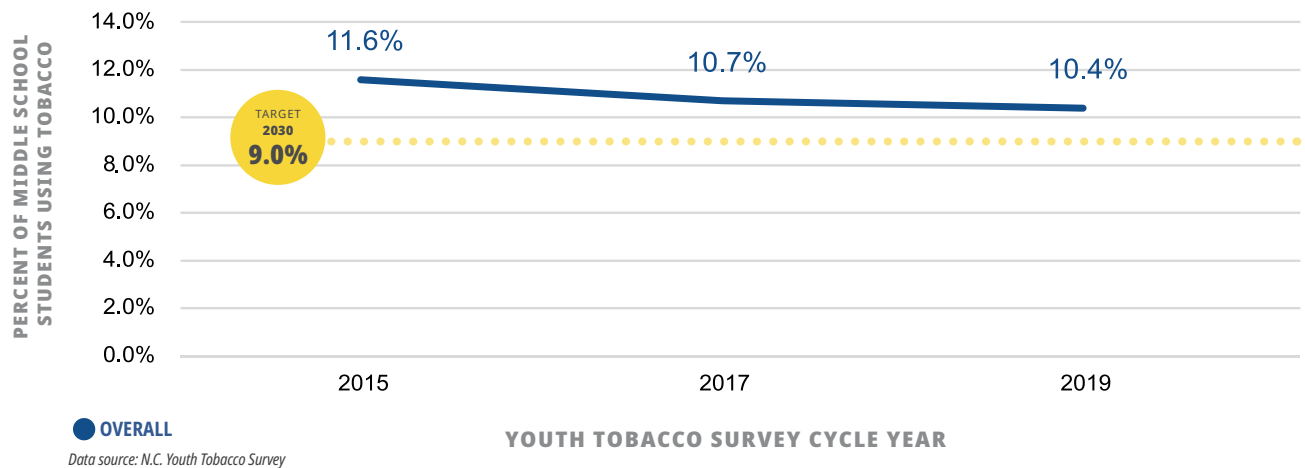


Figure 51. Tobacco use among middle school students in North Carolina by race/ethnicity (2015 - 2019)

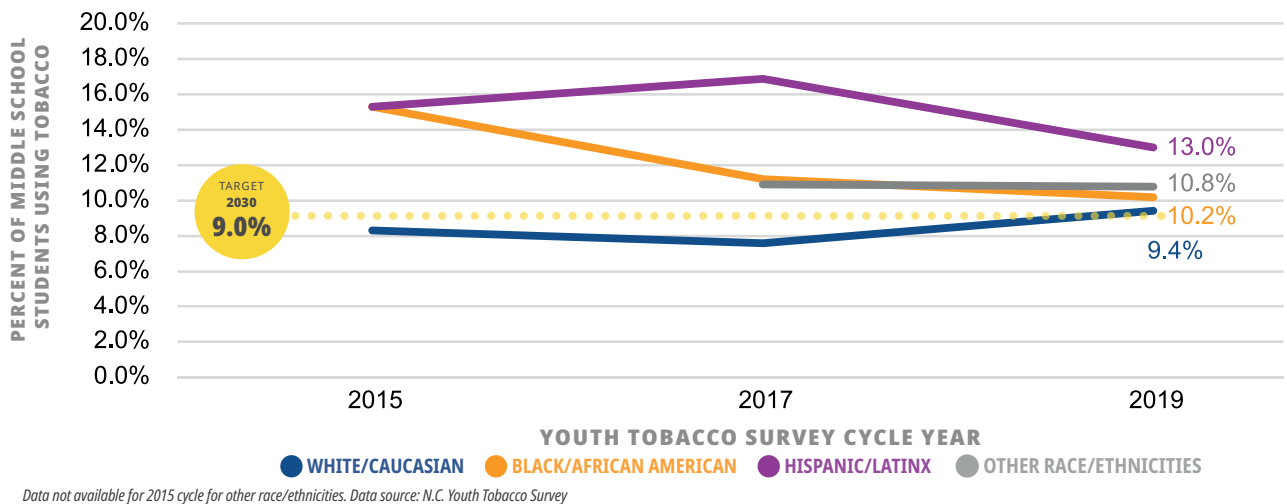
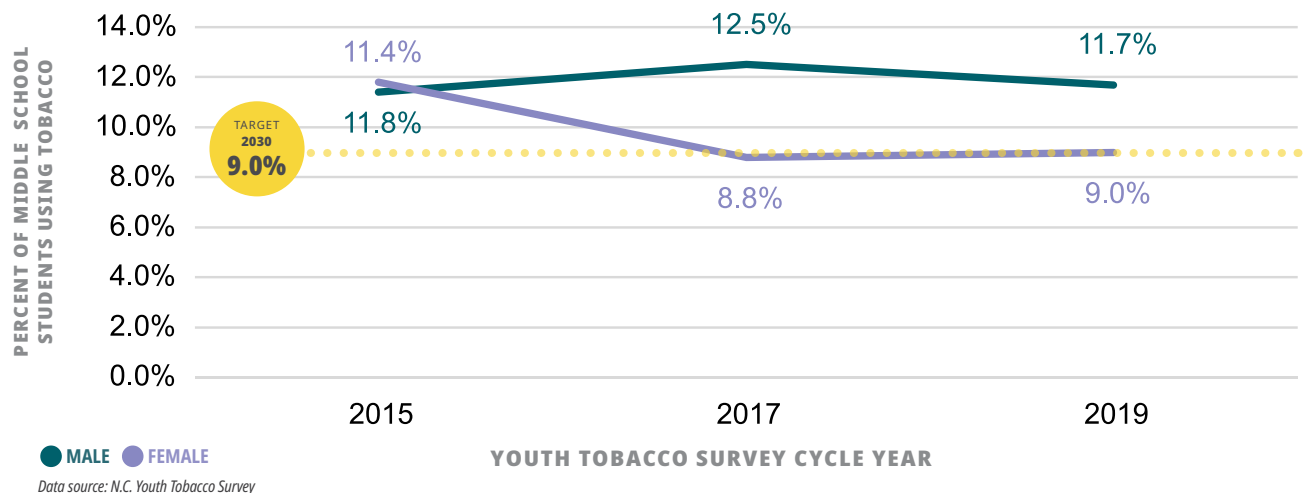


Figure 52. Tobacco use among middle school students in North Carolina by gender (2015 - 2019)



THE STORY BEHIND THE CURVE

- Almost half of all young people who have ever used a cigarette started with menthol
- Young people use e-cigarettes for social reasons and because they come in flavors
- 76% of youth under 21 who got their e-cigarettes from social sources got them from someone under 21
- 2 out of 3 of young people who currently use e-cigarettes are seriously thinking about quitting
- 24% of young people who have never tried an e-cigarette are open to trying one in the next year

Although a majority of cigarette smokers make a quit attempt each year in the United States, less than one-third use evidence-based methods which include FDA-approved tobacco treatment medications and behavioral counseling to support quit attempts. Nationally, one of the largest disparities is in the behavioral health population.²

WHAT OTHER DATA DO WE NEED?

- Rapid response data is needed for the tobacco marketplace
- Sale and consumption of new and emerging tobacco products
- Better understanding of health disparities regarding tobacco use and exposure to hazardous secondhand smoke and e-cigarette emissions
- Effectiveness of price policies to prevent initiation of e-cigarette use among young people
- Effectiveness of tobacco-free initiatives

WHAT COULD WORK TO TURN THE CURVE?

- Eliminate cigarettes from pharmacies
- Eliminate sale of loose cigars and cigarettes
- Enforce regulations that prohibit licensed tobacco retailers from selling tobacco products to underage buyers
- Enforce smoke-free multi-unit, public housing
- Expand Medicaid eligibility to include coverage for tobacco cessation treatment
- Fund comprehensive state tobacco control programs to levels recommended by CDC
- Implement state and local tobacco-free and smoke-free air policies that include electronic cigarettes
- Increase access to treatment based on the N.C. Tobacco Treatment Standard of Care, to include counseling and FDA-approved medications
- Increase number of paid staff at the state/local level to conduct comprehensive tobacco control programs
- Increase the number of tobacco-free public parks
- Increase the price of tobacco products by raising the current state tax on tobacco products
- Provide nicotine replacement options and services to the uninsured and underinsured
- Raise state minimum sales age from 18 to 21 and establish permitting of tobacco retailers
- Recommend an electronic cigarette policy for restaurants and bars
- Remove state preemption of local government regulations on the sale, promotion, distribution, and display of tobacco products
- Restrict the sales of flavored tobacco products
- Revise zoning ordinances to control placement of shops that sell tobacco, limiting the number of these shops per area and ensuring they are placed a safe distance from children's areas
- Support Tobacco Treatment Specialist Training for historically marginalized communities

RECOMMENDED READING/LISTENING

Smoking Cessation: A Report of the Surgeon General
<https://www.hhs.gov/sites/default/files/2020-cessation-sgr-full-report.pdf>

NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
American Heart Association - Triangle, Charlotte, Triad & Iredell County	https://www.heart.org/en/affiliates/north-carolina/triangle https://www.heart.org/en/affiliates/north-carolina/charlotte https://www.heart.org/en/affiliates/north-carolina/triad-region
American Lung Association	https://www.lung.org/ https://www.lung.org/quit-smoking
American Nonsmokers' Rights Foundation (ANRF)	https://no-smoke.org/
American Public Health Association (APHA)	https://www.apha.org/apha-communities/member-sections/community-health-workers
Association of State and Territorial Health Officials (ASTHO)-Tobacco Control Program	https://www.astho.org/About/
BlueCross BlueShield of North Carolina Foundation	https://www.bcbnsncfoundation.org/
BreatheEasyNC Becoming Tobacco Free	https://breatheeasync.org/
Campaign for Tobacco Free Kids	https://www.tobaccofreekids.org/
CDC's 6/18 Initiative	https://www.cdc.gov/sixteen/index.html https://www.cdc.gov/sixteen/tobacco/index.html
CenterLink- LGBT HealthLink	https://www.lgbthealthlink.org/ https://www.lgbtcenters.org/Programs
Change for Life: Tobacco Free Recovery	https://www.mecknc.gov/HealthDepartment/CommunityHealthServices/TobaccoFreeMecklenburg/Pages/Tobacco-Free-Behavioral-Health.aspx
Coordinated Approach to Child Health (CATCH) My Breath	https://letsgo.catch.org/bundles/catch-my-breath-e-cigarette-juul-prevention
Countertobacco.org	https://countertobacco.org/
Counter Tools	https://countertools.org/
Dogwood Health Trust	https://dogwoodhealthtrust.org/
Duke - UNC Tobacco Treatment Specialist Training Program	https://www.dukeuncts.com/
National Alliance on Mental Illness North Carolina	https://naminc.org/
National Association for Alcoholism and Drug Abuse Counselors (NAADAC)	https://www.naadac.org/about
National Association of Chronic Disease Directors (NACDD)	https://chronicdisease.org/
National Association of Social Workers North Carolina Chapter	https://www.naswnc.org/
National Council for Mental Wellbeing	https://www.thenationalcouncil.org/ https://www.thenationalcouncil.org/topics/national-behavioral-health-network-for-tobacco-cancer-control/
National Native Network	https://keepitsacred.itcmi.org/ https://keepitsacred.itcmi.org/quitlines/
North Carolina Alliance For Health (NCAH)	https://www.ncallianceforhealth.org/tobacco-use-prevention/
North Carolina American Indian Health Board	https://ncaihb.org/
North Carolina Area Health Education Centers (NC AHEC)	https://www.ncahec.net/healthy-north-carolina-2030/
North Carolina Association of Local Health Directors	https://www.ncalhd.org/
North Carolina Association of Pharmacists (NCAP)	https://www.ncpharmacists.org/
North Carolina Department of Public Instruction	https://www.dpi.nc.gov/
North Carolina Department of Public Safety- Juvenile Crime Prevention Councils	https://www.ncdps.gov/juvenile-justice/community-programs/juvenile-crime-prevention-councils
North Carolina Medical Board	https://www.ncmedboard.org/
North Carolina Public Health Association	https://ncpha.memberclicks.net/
Parents Against Vaping e-Cigarettes (PAVe)	https://www.parentsagainstvaping.org/
QuitlineNC	https://www.quitlinenc.com/
Rescue Agency	https://www.rescueagency.com/ https://www.rescueagency.com/work/case-studies
Robert Wood Johnson Foundation (RWJF)	https://www.rwjf.org/en/how-we-work/grants-explorer/funding-opportunities.html?cid=xps_other_pd_dte%3A20191105
School Nurse Association of North Carolina (SNANC)	https://www.snanc.com/home
The African American Tobacco Control Leadership Council (AATCLC)	https://www.savingblacklives.org/about
The Center for Black Health & Equity	https://centerforblackhealth.org/ https://centerforblackhealth.org/tobacco/
The Duke Endowment	https://www.dukeendowment.org/
Truth Initiative	https://truthinitiative.org/

WHAT RESULT DO WE WANT?

All North Carolina communities support safe and responsible use of alcohol.

WHY IS THIS IMPORTANT?

- Alcohol use is responsible for approximately 3,500 deaths annually among youth under age 21 in the United States, shortening their lives by an average of 60 years
- Underage alcohol use occurs in a context of significantly problematic adult use nationwide. Approximately 95,000 individuals of all ages in the United States die from alcohol-attributable causes each year, making excessive alcohol use the third leading preventable cause of death in the U.S.³

HNC 2030 HEADLINE INDICATOR:

Percent of adults reporting binge or heavy drinking

Source: Report to Congress on the Prevention and Reduction of Underage Drinking 2021

WHAT DOES THIS INDICATOR MEASURE?

HEAVY DRINKING is derived from two questions asked on the annual Behavioral Risk Factor Surveillance System survey:

1. "During the past 30 days, how many days per week or per month did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor? One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor."
2. "During the past 30 days, on the days when you drank, about how many drinks did you drink on the average?"

Heavy drinkers are:

- Women and men aged 65 or older who have 8 or more drinks per week.
- Men under 65 who have 15 or more drinks per week.

BINGE DRINKING is derived from a question asked on the annual Behavioral Risk Factor Surveillance System survey:

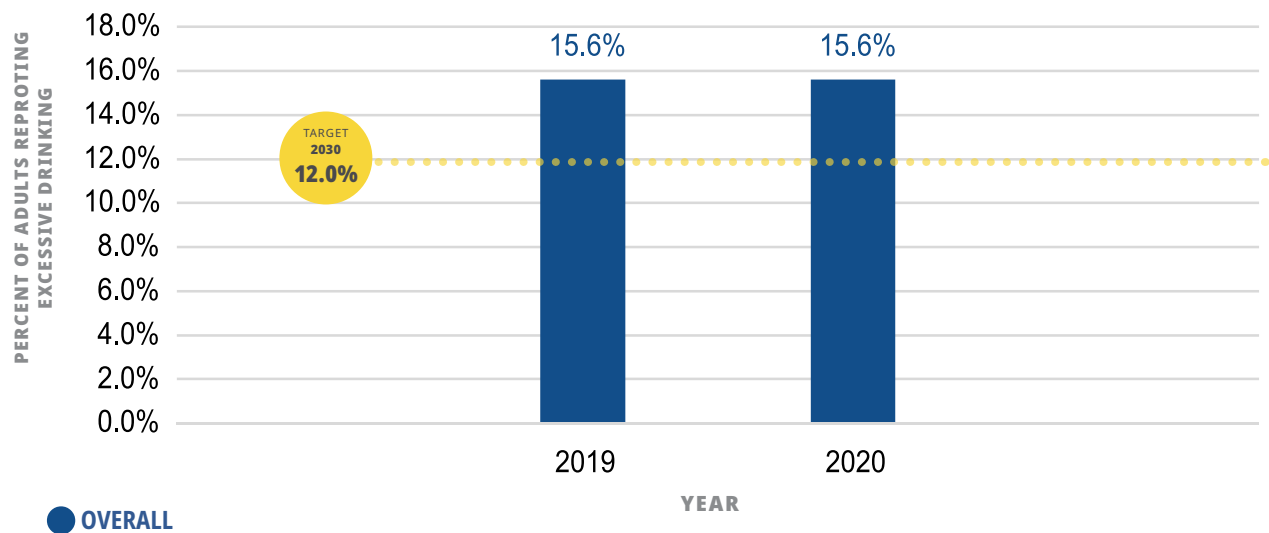
1. "Considering all types of alcoholic beverages, how many times during the past 30 days did you have [5 for men, 4 for women] or more drinks on an occasion?"
- Binge drinkers are respondents who report one or more episodes.

BASELINE DATA FROM HNC 2030**HOW ARE WE DOING?**

- The percent of adults who report excessive drinking continues to exceed the *HNC 2030* target of 12.0%

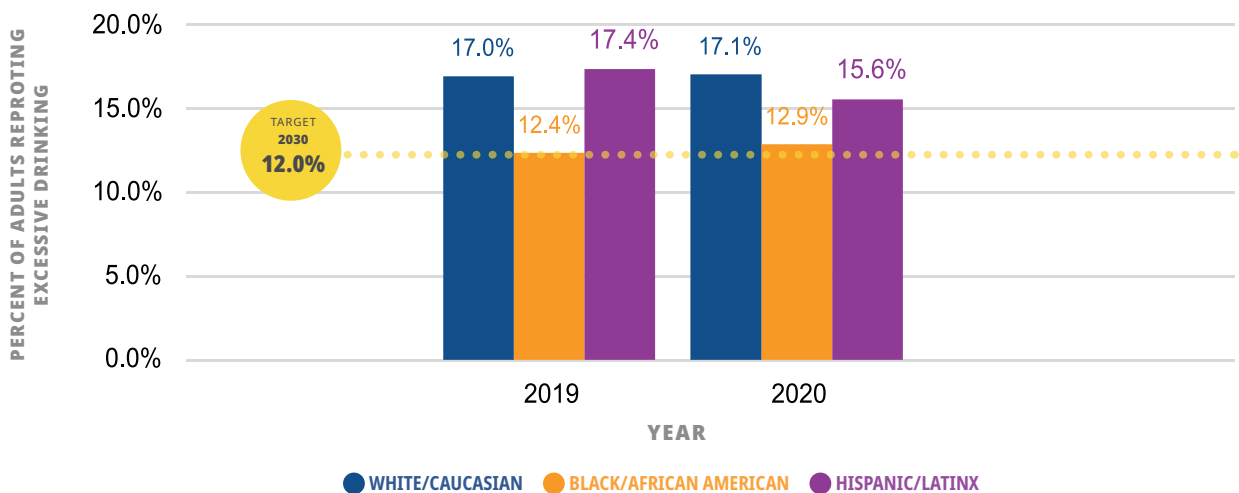
CURRENT DATA TRENDED OVER TIME

Figure 53. Excessive drinking in North Carolina (2019 - 2020)



Data source: Behavioral Risk Factor Surveillance System (BRFSS), N.C. State Center for Health Statistics

Figure 54. Excessive drinking in North Carolina by race/ethnicity (2019 - 2020)



Data not available for Asian/Pacific Islanders. Data source: Behavioral Risk Factor Surveillance System (BRFSS), N.C. State Center for Health Statistics

THE STORY BEHIND THE CURVE

Alcohol consumption increased during the COVID-19 pandemic in 2020 in the United States. The increase could substantially increase the long-term alcohol-associated liver disease (ALD) and mortality.¹

WHAT OTHER DATA DO WE NEED?

- Alcohol data dashboard available – includes density of alcohol retailers/map/economic costs/national study based on population
- Alcohol sales data per county
- Estimate of alcohol availability from illegal sales and practices
- Map of points of liquor sales in the community
- Violent Death Reporting System – tracks whether alcohol was involved in a death
- Number of criminal offenders under the influence when crime was committed
- Number of emergency room visits for alcohol related injuries and conditions
- Economic cost of alcohol-related injuries and conditions
- Availability of inpatient and outpatient treatment and counseling programs
- Alcoholics Anonymous (AA) locations and meeting times
- Better alcohol consumption data for ages 18-20
- Issues/limitations collecting data for younger populations

WHAT COULD WORK TO TURN THE CURVE?

- Consider local ordinances related to the sale and consumption of alcohol at local events
- Enforce state laws restricting beer and wine couponing
- Expand Medicaid eligibility
- Hold alcohol retailers liable for intoxicated or underage customers who cause injury to others
- Increase alcohol excise taxes
- Increase funding for compliance audits
- Increase number and access to programs
- Integrate the process of Screening, Brief Intervention, and Referral to Treatment (SBIRT) into medical settings
- Reduce density of alcohol retailer establishments
- Reduce the days and hours of alcohol sales
- Support and maintain state-controlled alcohol sales

RECOMMENDED READING/LISTENING

Report to Congress on the Prevention and Reduction of Underage Drinking 2021.

https://www.stopalcoholabuse.gov/media/ReportToCongress/2021/report_main/2021_Report_to_Congress.pdf

NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
Addiction Professionals North Carolina	https://www.apnc.org/
Centers for Disease Control's Community Guide on Preventing Excessive Alcohol Consumption	https://www.thecommunityguide.org/topic/excessive-alcohol-consumption
Forensic Tests for Alcohol - NC DPH Branch	https://publichealth.nc.gov/chronicdiseaseandinjury/fta/index.htm
Mothers Against Drunk Driving North Carolina	https://www.madd.org/north-carolina/
National Alcoholic Beverage Control Association (NABCA)	https://www.nabca.org/
North Carolina Area Health Education Centers (NC AHEC)	https://www.ncahec.net/healthy-north-carolina-2030/
North Carolina Fetal Alcohol Syndrome Disorder (FASD) Informed	https://ncfasdinformed.org/about-us/about-ncfasd-informed
North Carolina Preventing Underage Drinking Initiative (PUDI) - Talk It Up. Lock It Up!	https://www.ncpudi.org/
North Carolina Substance Use Disorder Federation	https://sudfederation.org/
Recovery Communities of North Carolina (RCNC)	https://www.rcnc.org/
The Center for Alcohol Policy	https://www.centerforalcoholpolicy.org/
The Center for Prevention & Counseling - Too Smart to Start	https://centerforprevention.org/too-smart-to-start/



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WHAT RESULT DO WE WANT?

All people in North Carolina live in communities that support healthy food and beverage choices.

WHY IS THIS IMPORTANT?

Sugar-sweetened beverages (SSBs) or sugary drinks are leading sources of added sugars in the American diet. Frequently drinking SSB is associated with weight gain, obesity, type 2 diabetes, heart disease, kidney diseases, non-alcoholic liver disease, tooth decay and cavities, and gout, a type of arthritis. Limiting sugary drink intake can help individuals maintain a healthy weight and have healthy dietary patterns.¹

WHAT DOES THIS INDICATOR MEASURE?

ADULTS

Derived from two questions asked on annual Behavioral Risk Factor Surveillance System (BRFSS) survey:

- 1. "During the past 30 days, how often did you drink regular soda or pop that contains sugar? Do not include diet soda or diet pop."
- 2. "During the past 30 days, how often did you drink sugar-sweetened fruit drinks (such as Kool-Aid and lemonade), sweet tea, and sports or energy drinks (such as Gatorade and Red Bull). Do not include 100% fruit juice, diet drinks, or artificially sweetened drinks."

Respondent gives the number of times per day, week, or month. Answers are recoded to yield number of SSB per day. The annual survey data are reported annually beginning in 2021 and available for the state with breakdowns for North Carolina Medicaid regions, Local Health Director regions, and Eastern North Carolina, the Piedmont, and Western North Carolina.

YOUTH

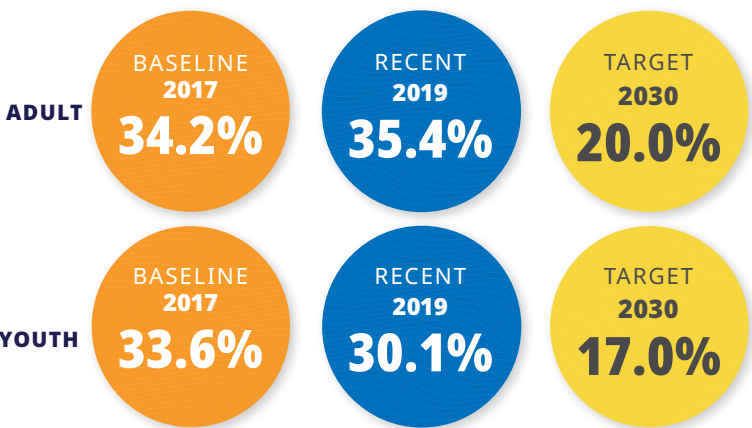
Data from NC Healthy Schools Youth Risk Behavior Survey (YRBS)

Students in grades 9 through 12 were asked two survey questions with multiple choice answers in order to collect data for the measure:

- 1. "During the past 7 days, how many times did you drink a can, bottle, or glass of soda or pop, such as Coke, Pepsi, or Sprite? (Do not count diet soda or diet pop.)"
- 2. "During the past 7 days, how many times did you drink a can, bottle, or glass of a SSBs such as sports drinks (for example, Gatorade or PowerAde), energy drinks (for example, Red Bull or Jolt), lemonade, sweetened tea or coffee drinks, flavored milk, Snapple, or Sunny Delight? (Do not count soda or pop or 100% fruit juice.)"

NC Department of Public Instruction (NC DPI) makes counts, percentages and confidence intervals for those percentages available every 2 years.

BASELINE DATA FROM HNC 2030



HNC 2030 HEADLINE INDICATOR:

Percent of youth and adults reporting consumption of one or more sugar-sweetened beverages (SSBs) per day

- SSB Consumption among students in grades 9 through 12
- SSB consumption among adults

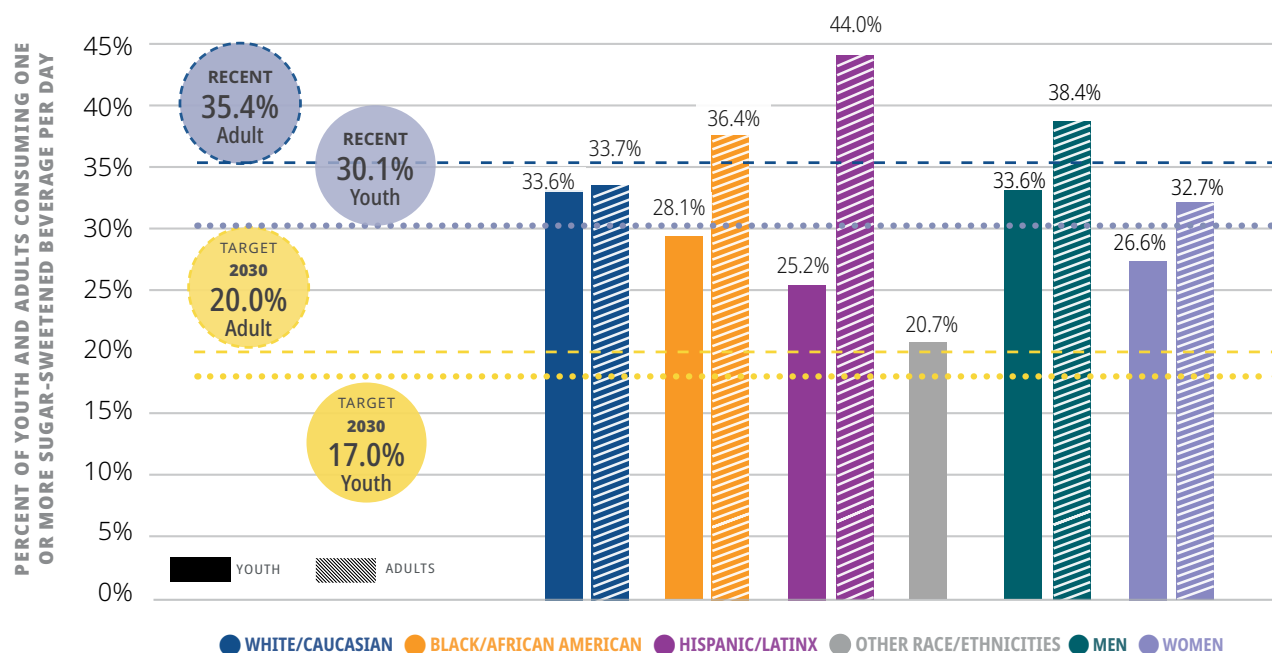
HOW ARE WE DOING?

- SSB consumption questions became a part of the annual Behavioral Risk Factor Surveillance System questions in 2021
- The Youth Risk Behavior Survey was last conducted in 2019

In 2017, 33.6% of high school students and 34.2% of adults in North Carolina reported consumption of one or more SSBs per day. Men, individuals in low-income households, individuals with low levels of educational attainment, and individuals that have parents with low levels of educational attainment report higher SSB consumption. Perception of tap water and targeted marketing to youth of color and low-income populations contribute to differences in SSB consumption across racial groups. The goal for the next 10 years is to decrease youth consumption of SSBs to from 33.6% to 17% and decrease adult consumption from 34.2% to 20.0%.²

CURRENT DATA TRENDED OVER TIME

Figure 55. Sugar-sweetened beverage consumption across populations in North Carolina and distance to 2030 target



Data Source: 2019 Youth Behavior Risk Survey (YBRS) and 2019 Behavioral Risk Factor Surveillance System (BRFSS)

THE STORY BEHIND THE CURVE

- In 2011-2014, 6 in 10 youth (63%) and 5 in 10 adults (49%) drank an SSB on a given day. On average, US youth consumed 143 calories from SSBs and US adults consumed 145 calories from SSBs on a given day.
- Among youth, SSB intake is higher among boys, adolescents, non-Hispanic Black youth, or youth in families with low incomes.
- Among adults, SSB intake is higher among males, young adults, non-Hispanic Black or Mexican American adults, or adults with low incomes.
- The prevalence of Americans who drink sugary drinks at least once per day differs geographically.
- For example, 68% of adults living in the Northeast, 67% of adults living in the South, 61% of adults living in the West, and 59% of adults living in the Midwest reported drinking SSBs one or more times per day.
- About 31% of adults in nonmetropolitan counties and 25% of adults in metropolitan counties reported drinking SSBs one or more times per day.
- Americans drink 52% of SSB calories at home and 48% of SSB calories away from home.

Source: CDC/Nutrition/Data and Statistics

WHAT OTHER DATA DO WE NEED?

- School and child care policies on SSB sales and consumption
- Early childhood programs participating in Nutrition and Physical Activity Self-Assessment for Child Care (NAPSACC)
- Water quality in communities
- Consider adding sugar-sweetened coffees to survey data

WHAT COULD WORK TO TURN THE CURVE?

- Establish healthy food procurement policies that support public and private investment in healthy food, and increase availability of healthy alternatives to sugary drinks
- Implement a sugar-sweetened beverages (SSBs) tax with revenues to address equity issues
- Integrate “Rethink Your Drink” Division of Child Development Supplemental Nutrition and Assistance Program Education toolkit into school curricula, promoting water as healthy alternative to sweetened beverages
- Limit “default beverage” options for children’s meals in restaurant and educational settings to include only milk, 100% fruit juice, or water
- Recommend NC Department of Public Instruction (DPI) adopt a statewide policy permitting students to bring water bottles to school (containing only water)
- Work with clinicians, medical practices, and insurance providers to add SSB screening questions to patients’ electronic health records

RECOMMENDED READING/LISTENING

Rethink Your Drink: Options for reducing the number of calories you drink.
<https://tools.cdc.gov/medialibrary/index.aspx#/media/id/302830>

CDC Podcast: Sugary Drinks; Curb the Colas.
<https://tools.cdc.gov/medialibrary/index.aspx#/media/id/305535>

NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
Clean Water for Carolina Kids	https://www.cleanwaterforcarolinakids.org/
Color Me Healthy (CMH)	https://snapedtoolkit.org/interventions/programs/color-me-healthy-cmh/
Diabetes Management NC - DiabetesSmart NC	https://diabetesmanagementnc.com/diabetessmart/
Duke Sanford World Food Policy Center	https://wfpc.sanford.duke.edu/
Durham’s Innovative Nutrition Education (DINE)- Supplemental Nutrition Assistance Program Education (SNAP-Ed)	https://snaped.fns.usda.gov/success-stories/durhams-innovative-nutrition-education-dine
Eat Smart, Move More North Carolina	https://www.eatsmartmovemorenc.com/
Eat Smart, Move More, Prevent Diabetes	https://esmmpreventdiabetes.com/
Eat Smart, Move More, Weigh Less	https://esmmweighless.com/
Go NAPSACC	https://gonapsacc.org/
Healthy Eating Research - Healthy Drinks Healthy Kids	https://healthydrinkshealthykids.org/
NC Cooperative Extension - Eat Smart, Move More, Take Control	https://richmond.ces.ncsu.edu/take-control-2/
North Carolina Area Health Education Centers (NC AHEC)	https://www.ncahec.net/healthy-north-carolina-2030/
North Carolina Expanded Food and Nutrition Education Program (EFNEP)	https://ncefne.org/what-is-efnep/
UNC Center for Health Promotion and Disease Prevention	https://hdpd.unc.edu/research/cardiovascular-health-obesity-diabetes/ https://hdpd.unc.edu/research/nutrition-physical-activity/
North Carolina Council of Churches - Partners in Health and Wholeness (PHW) initiative	https://www.ncchurches.org/programs/phw/



AMOUNT OF SUGAR AND CALORIES IN COMMON DRINKS

Sugar content derived from US Department of Agriculture Food Data Central

DRINK (12-OUNCE SERVING)	TEASPOONS OF SUGAR	TOTAL DRINK CALORIES
Tap or Unsweetened Bottled Water	0	0
Unsweetened Tea	0	0
Lemonade, powder, prepared with water	3	55
Sports Drinks	5	97
Brewed Sweet Tea	7	115
Energy Drink	9	162
Regular Soda	10	155
Fruit Juice Drink	10	186
Regular Orange Soda	13	195

Source: Centers for Disease Control and Prevention. *Rethink Your Drink*
https://www.cdc.gov/healthyweight/healthy_eating/drinks.html

WHAT RESULT DO WE WANT?

All people in North Carolina experience sexual health with equitable access to quality and culturally competent prevention, treatment, and management of sexually transmitted infections.

WHY IS THIS IMPORTANT?

HIV can cause lifelong physical and psychological consequences. When left untreated, HIV can also be transmitted to sexual partners and unborn children.

HNC 2030 HEADLINE INDICATOR:

Number of new HIV diagnoses
per 100,000 population

WHAT DOES THIS INDICATOR MEASURE?

The indicator measures new HIV infections.

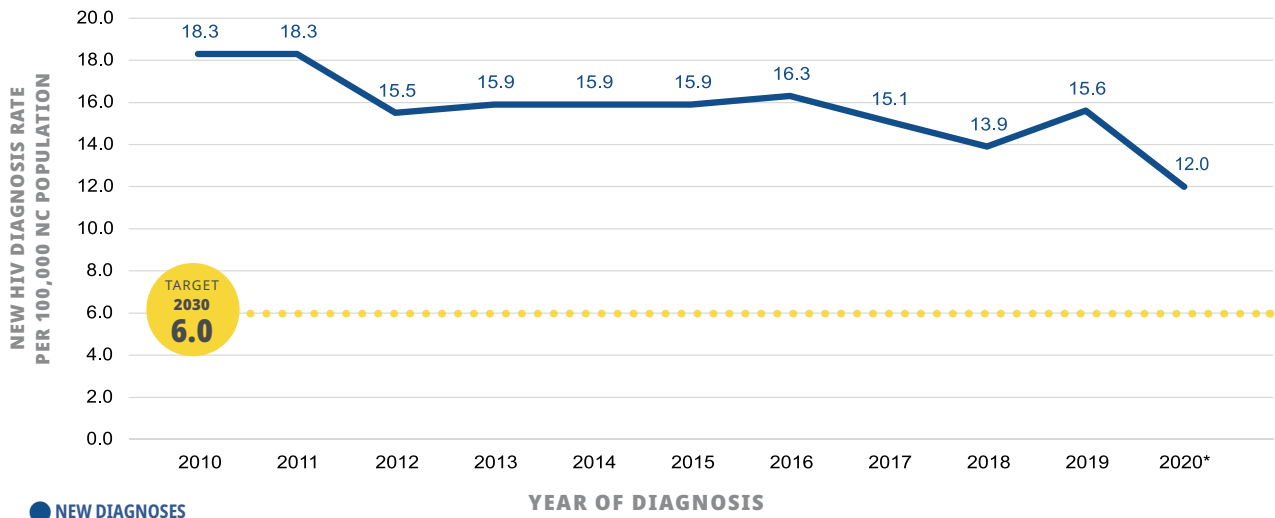
Data are obtained from case investigations at the county level and reported electronically to the NC Electronic Disease Surveillance System (NCEDSS). Cases include physician and laboratory reports of infection. Case investigation data for this disease are legally reportable in the United States and in North Carolina.

BASELINE DATA FROM HNC 2030**HOW ARE WE DOING?**

- The estimated rate of HIV infection rates among newly diagnosed adults and adolescents is highest among Black/ African Americans, 13 to 30 years old, and to those who identify as gay, bisexual men, or as men having sex with other men.
- 2020 data should be treated with caution due to reduced availability of testing caused by the COVID-19 pandemic.
- Because the total number of transgender people living in North Carolina is not known, rates for HIV diagnosis in transgendered individuals cannot be calculated.
- People with lower income, who lack access to quality and culturally competent health care, sex workers, and incarcerated individuals have higher rates of diagnosis and lack resources for prevention and treatment of HIV.¹

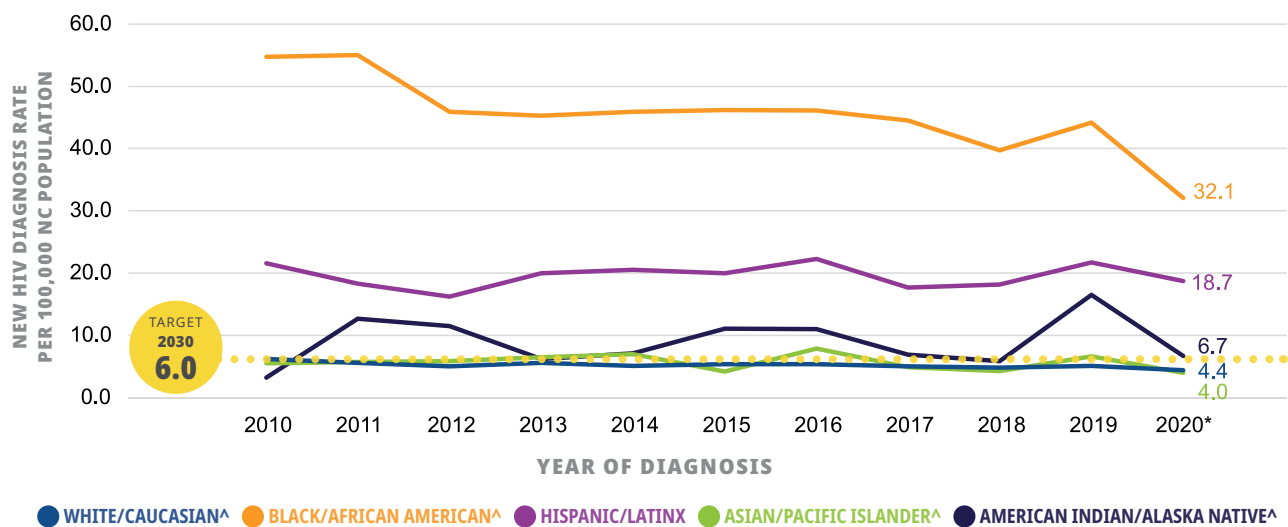
CURRENT DATA TRENDED OVER TIME

Figure 56. North Carolina newly diagnosed HIV rates (2010 - 2020*)



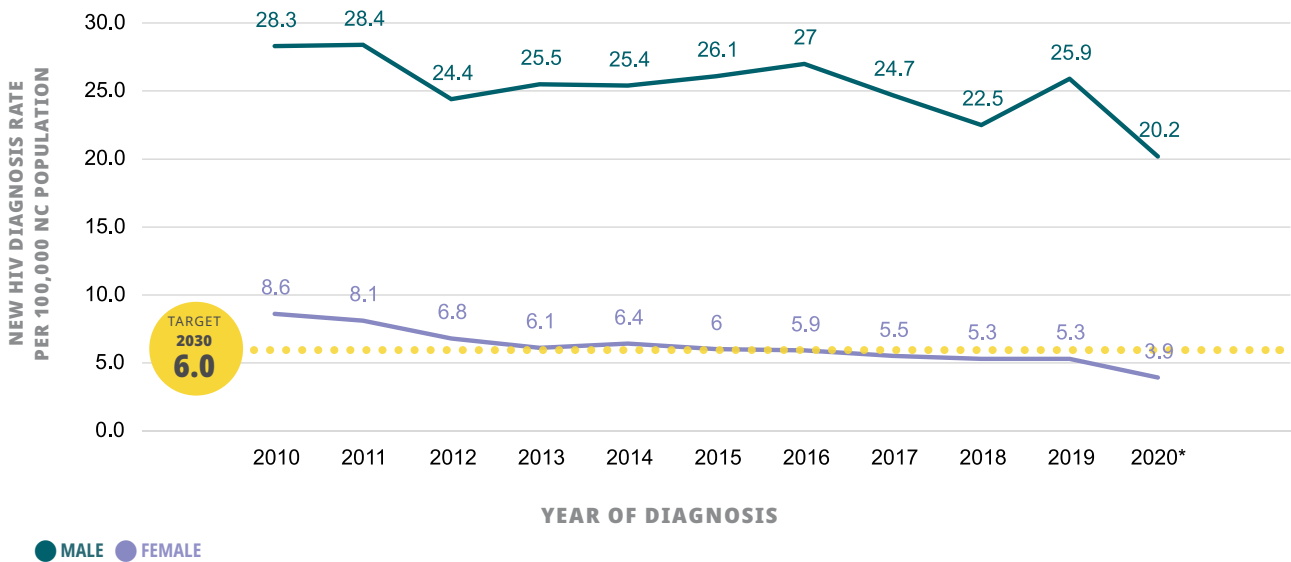
*2020 data should be treated with caution due to reduced availability of testing caused by the COVID-19 pandemic. Because the total number of transgender people living in North Carolina is not known, rates for HIV diagnosis in transgendered cannot be calculated. However, numbers of transgender people living with HIV in North Carolina are available in our annual report: <https://epi.dph.ncdhs.gov/cd/stds/annualrpts.html>
Data Source: enhanced HIV/AIDS Reporting System (eHARS) (data as of June 28, 2021).

Figure 57. North Carolina newly diagnosed HIV by race/ethnicity (2010 - 2020*)



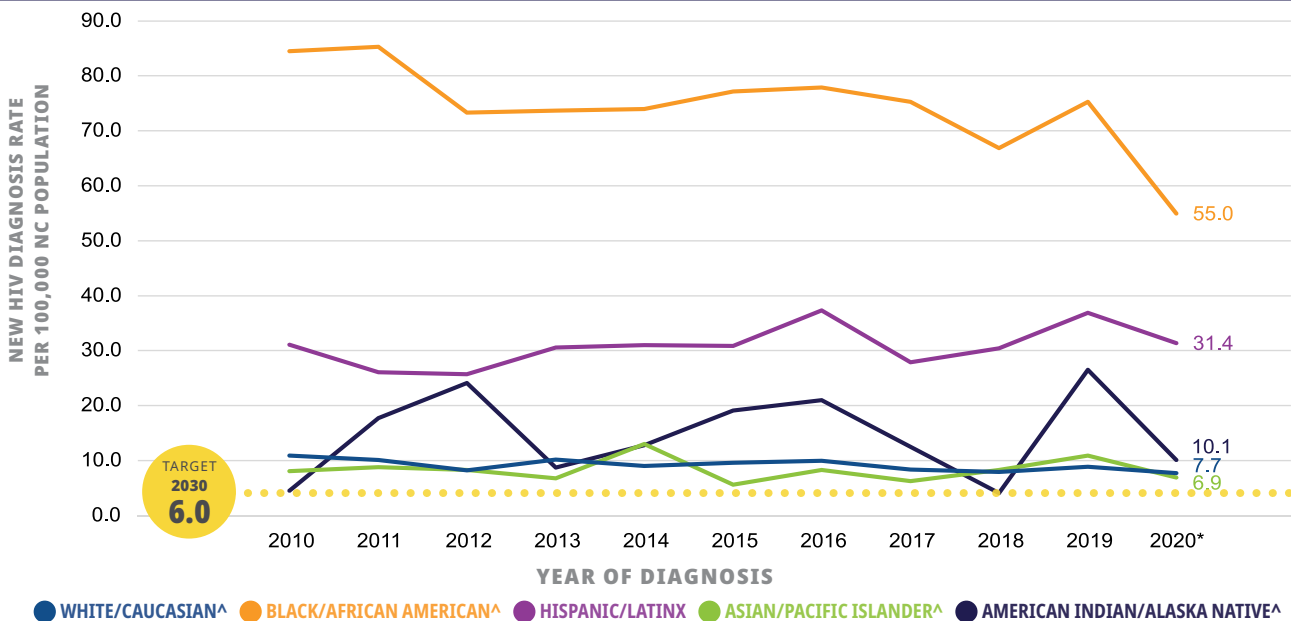
*2020 data should be treated with caution due to reduced availability of testing caused by the COVID-19 pandemic. [^]Non-Hispanic/LatinX. Data Source: enhanced HIV/AIDS Reporting System (eHARS) (data as of June 28, 2021).

Figure 58. North Carolina newly diagnosed HIV By gender (2010 - 2020*)



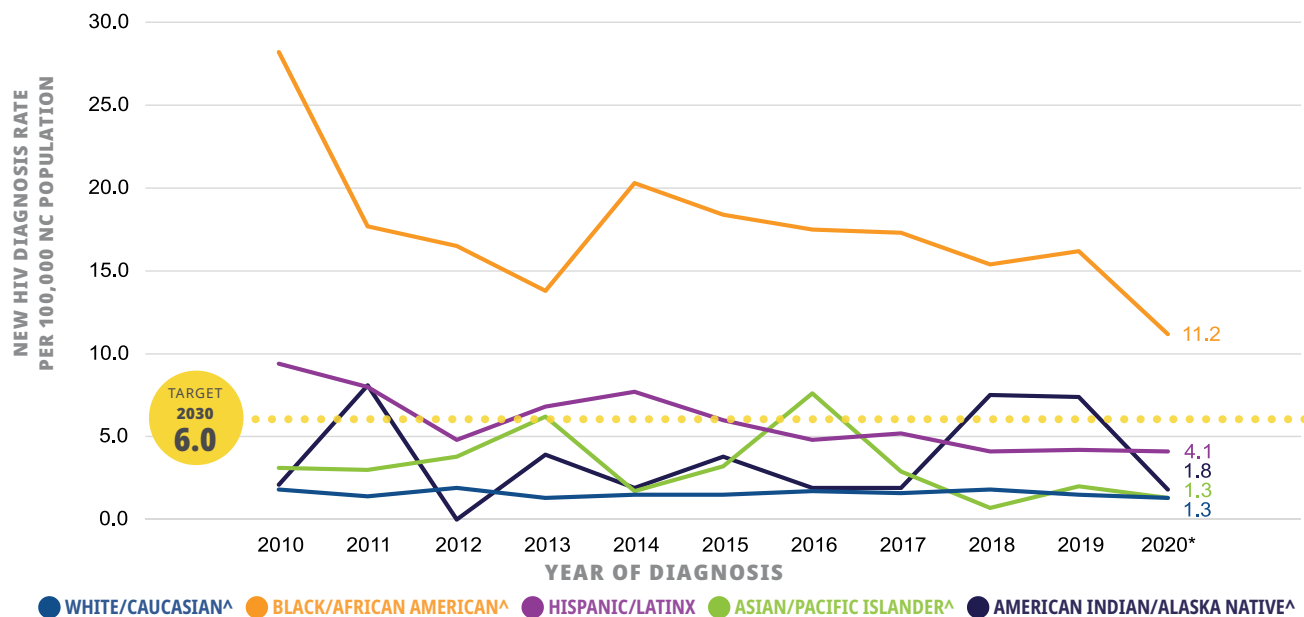
*2020 data should be treated with caution due to reduced availability of testing caused by the COVID-19 pandemic. Because the total number of transgender people living in North Carolina is not known, rates for HIV diagnosis in transgendered cannot be calculated. However, numbers of transgender people living with HIV in North Carolina are available in our annual report: <https://epi.dph.ncdhs.gov/cd/stds/annualrpts.html>
Data Source: enhanced HIV/AIDS Reporting System (eHARS) (data as of June 28, 2021).

Figure 59. North Carolina newly diagnosed HIV among men (2010 - 2020*)



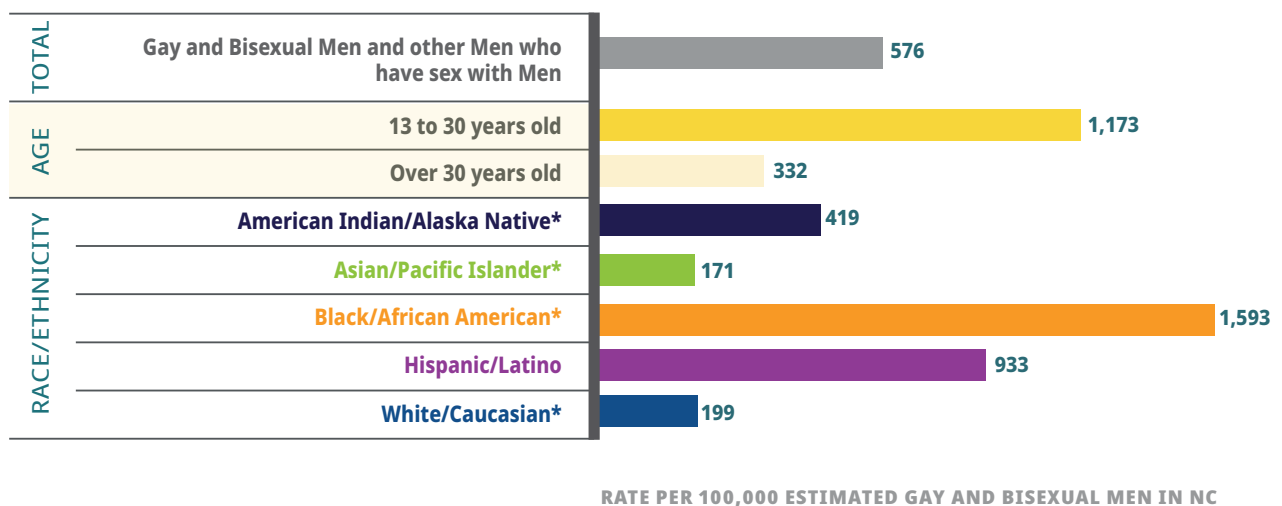
*2020 data should be treated with caution due to reduced availability of testing caused by the COVID-19 pandemic. Because the total number of transgender people living in North Carolina is not known, rates for HIV diagnosis in transgendered cannot be calculated. However, numbers of transgender people living with HIV in North Carolina are available in our annual report: <https://epi.dph.ncdhs.gov/cd/stds/annualrpts.html>
Data Source: enhanced HIV/AIDS Reporting System (eHARS) (data as of June 28, 2021).

Figure 60. North Carolina newly diagnosed HIV among women (2010 - 2020*)



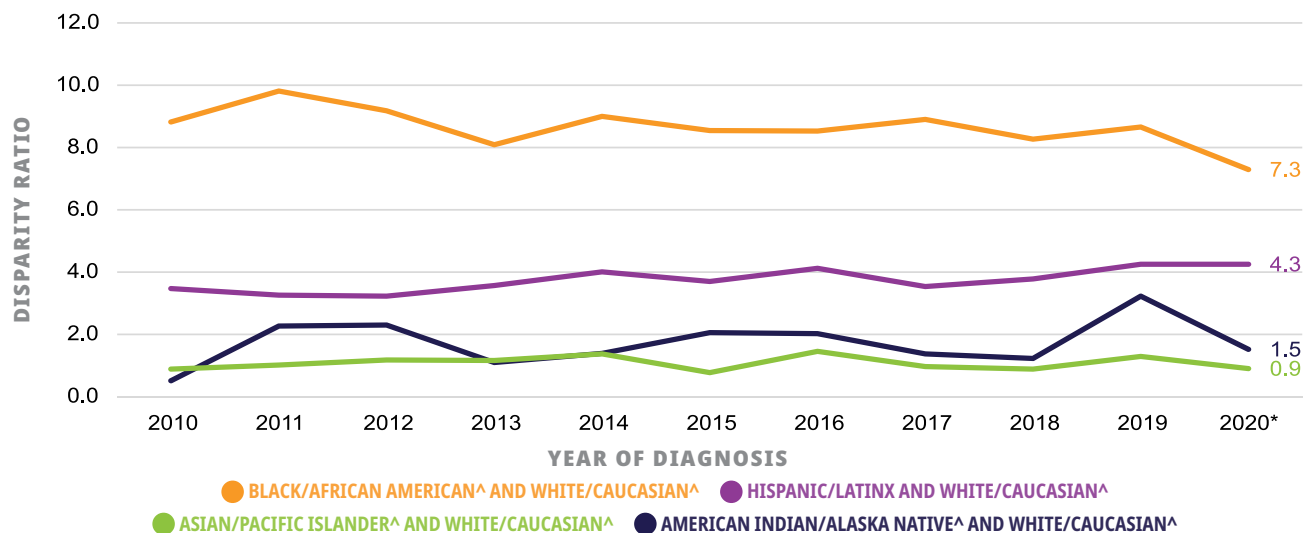
*2020 data should be treated with caution due to reduced availability of testing caused by the COVID-19 pandemic. Because the total number of transgender people living in North Carolina is not known, rates for HIV diagnosis in transgendered cannot be calculated. However, numbers of transgender people living with HIV in North Carolina are available in our annual report: <https://epi.dph.ncdhhs.gov/cd/stds/annualrpts.html>
 Data Source: enhanced HIV/AIDS Reporting System (eHARS) (data as of June 28, 2021).

Figure 61. Estimated HIV infection rates among newly diagnosed adult and adolescents (13 years and older) gay and bisexual men and other men who have sex with other men^ in North Carolina (2020)



Note: 2020 data should be treated with caution due to reduced availability of testing caused by the COVID-19 pandemic. Data is italicized for this reason. ^Unknown risk has been redistributed. People who were classified as MSM and IDU were excluded. ^^Grey et al (2016). JMIIR Public Health Surveill; 2(1): e14. <https://publichealth.jmir.org/2016/1/e14/> *Non-Hispanic/LatinX. Data Source: enhanced HIV/AIDS Reporting System (eHARS) (data as of June 28, 2021)

Figure 62. North Carolina disparities in new HIV diagnoses among race/ethnicities (2010 - 2020*)



THE STORY BEHIND THE CURVE

Thousands of people in the United States are diagnosed with HIV every year. Many people have HIV for years before they know it. Testing everyone ages 13 to 64 years for HIV at least once in their lifetime — and testing people at high risk for HIV at least once a year — can lead to early diagnosis and treatment.²

People must feel safe when seeking health care. This means acknowledging the person respectfully – especially for transgender individuals. Good quality sexual health education across the lifespan helps to normalize and integrate sexual health as a standard component of overall health awareness. Clinical staff must receive training specific to clinical care for transgender people.

Non-traditional testing and notification systems are needed. These could include multiple ways for people to notify other people of exposure, such as a website for anonymous contact notification. Home based STI testing and virtual clinical visits could improve early detection.

WHAT OTHER DATA DO WE NEED?

- Time to treatment from initial diagnosis – consider a metric for multiple sexually transmitted infections (STIs)
- Incidence of gonorrhea and chlamydia because of its higher prevalence
- Availability of PrEP (pre-exposure prophylaxis) within community
- Map coverage of social media platforms used by the at-risk community
- Distribution of screening and testing opportunities to evaluate equitable access to care
- Community awareness of sexual health

WHAT COULD WORK TO TURN THE CURVE?

- Address systemic issues of provider discomfort with discussions about sexual health, including HIV by providing continuing professional development through NC AHEC and expansion of medical school curriculum
- Allow pharmacists to dispense post-exposure prophylaxis regimens
- Expand affordable housing programs and increase number of harm-reduction programs, including needle exchange programs
- Expand Medicaid eligibility for HIV-related healthcare
- Expand North Carolina's provider network for HIV care
- Implement High Impact Prevention (HIP) through coordinated interventions focused on increasing the number of people who are aware of their HIV status and increase access to prevention and treatment
- Increase access (PrEP) for individuals at high risk for HIV transmission
- Increase education and healthcare access for formerly incarcerated populations
- Increase same day access to a full array of contraceptive options in health care setting

RECOMMENDED READING/LISTENING

Ending the HIV Epidemic in the U.S. <https://www.cdc.gov/endhiv/index.html>

NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
Carolinas CARE Partnership	https://www.carolinascare.org/
Duke PrEP Clinic For HIV Prevention	https://www.dukehealth.org/locations/duke-prep-clinic-hiv-prevention
Durham County Department of Public Health - Formerly Incarcerated Transitions (FIT) Program	https://www.dcopublichealth.org/services/std-hiv-testing
Equality North Carolina	https://equalitync.org/issues/hiv_aids_work/
Getting To Zero Mecklenburg	https://www.mecknc.gov/HealthDepartment/GettingToZero/Pages/Home.aspx
NC Council of Churches- Growing Communities of Inclusion: A Faithful Response to HIV/AIDS	https://www.ncchurches.org/growing-communities-of-inclusion-a-faithful-response-to-hiv/
NC DHHS HIV Care Program	https://epi.dph.ncdhhs.gov/cd/hiv/program.html
NC DHHS Medicaid Be Smart Family Planning Program	https://ncgov.servicenowservices.com/sp_beneficiary?id=kb_article&sys_id=389050c51b5424906aacdb1ee54bcb8&table=kb_knowledge
NC DHHS NC HIV/AIDS Prevention and Care Advisory Committee (HPCAC)	https://epi.dph.ncdhhs.gov/cd/stds/programs/hpcac.html
NC DHHS North Carolina Injury & Violence Prevention Branch- North Carolina Safer Syringe Initiative	https://www.injuryfreenc.ncdhhs.gov/
North Carolina AIDS Action Network (NCAAN)	http://www.ncaan.org/
North Carolina Area Health Education Centers (NC AHEC)	https://www.ncahec.net/healthy-north-carolina-2030/
North Carolina Association of Pharmacists (NCAP)	https://www.ncpharmacists.org/
NC Board of Pharmacy	http://www.ncbop.org/
North Carolina Community Health Center Association (NCCHCA)	https://www.ncchca.org/
North Carolina Harm Reduction Coalition (NCHRC) - Syringe Exchange Program	https://www.nchrc.org/about/
NC Institute of Medicine (NCIOM)	https://nciom.org/
North Carolina Sheriff's Association (NCSA)	https://ncsheriffs.org/
Regional AIDS Interfaith Network (RAIN)	RAIN (carolinarain.org)
Society for Public Health Education (SOPHE)	https://www.sophe.org/
Southeast STD/HIV Prevention and Training Center	https://nnptc.org/locations/southeast-stdhiv-prevention-training-center
The North Carolina Barbers Association	https://www.ncbarbae.com/home
The Task Force For Global Health - Coalition for Global Hepatitis Elimination	https://taskforce.org/viral-hepatitis/
UNC Center for Health Equity Research (CHER) - TRANSforming the Carolinas Project	https://www.med.unc.edu/cher/

WHAT RESULT DO WE WANT?

All people in North Carolina live in communities that support healthy choices for family planning and have equitable access to high quality, affordable reproductive health services.

WHY IS THIS IMPORTANT?

Teenage mothers are more likely to face higher rates of pregnancy-related morbidity, are less likely to receive prenatal care, and experience greater hardships that negatively impact their children's life and their own.

HNC 2030 HEADLINE INDICATOR:

Number of births to females aged 15-19 per 1,000 population

WHAT DOES THIS INDICATOR MEASURE?

$$\text{TEEN BIRTH RATE} = \frac{\text{Number of births to women ages 15-19 years}}{\text{Number of women ages 15-19 years}} \times 1,000$$

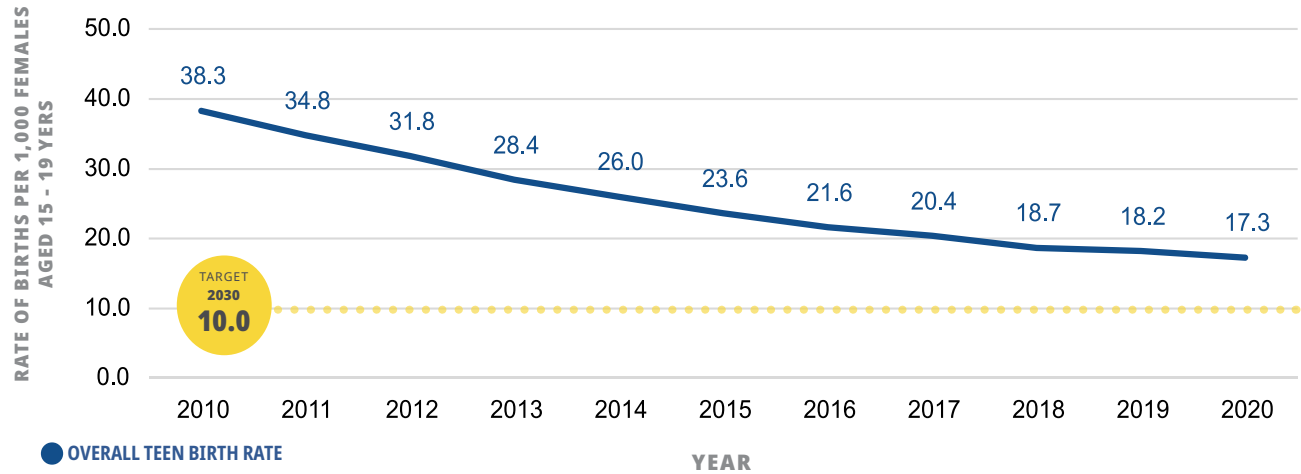
The data are produced annually using ages and counts from resident Birth Certificate data. The data are disaggregated by county, race, and perinatal care region. This indicator is often referred to as the fertility rate.

BASELINE DATA FROM HNC 2030**HOW ARE WE DOING?**

- Births to females aged 15-19 years old have seen a steady decline across all race/ethnicities since 2010.
- Hispanic/Latinx and American Indian/Alaska Native teens have the highest rates of teen births.

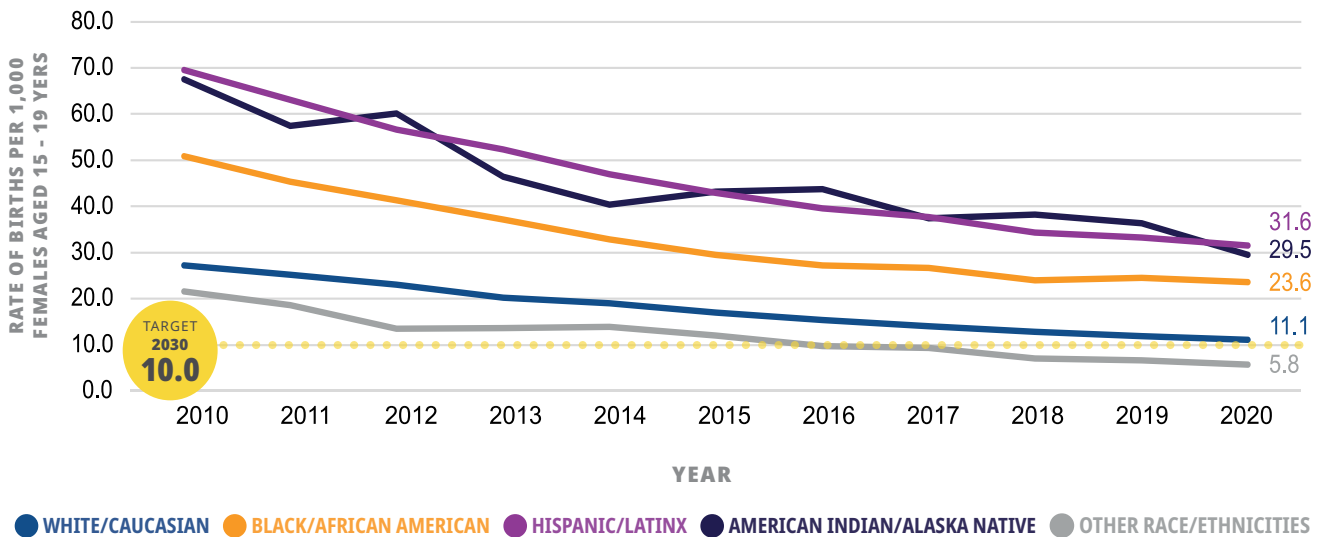
CURRENT DATA TRENDED OVER TIME

Figure 63. Teen birth rates for females aged 15 - 19 years in North Carolina (2010 - 2020)



Data source: N.C. State Center for Health Statistics, Vital Statistics

Figure 64. Teen birth rate for females aged 15 - 19 years by race/ethnicity in North Carolina (2010 - 2020)



Data not available for Asian/Pacific Islanders. Data source: N.C. State Center for Health Statistics, Vital Statistics

THE STORY BEHIND THE CURVE

According to the National Campaign to Prevent Teen and Unplanned Pregnancy, teen childbearing costs taxpayers in North Carolina over \$325 million annually, and nationally the annual cost is over \$9.4 billion.¹ Additionally, pregnancy and birth are significant contributors to high school dropout rates among girls, with only about 50 percent of teen mothers receiving a high school diploma by age 22, compared to 90 percent of women who do not give birth as a teen.² Teen mothers are also more likely to rely on public assistance, be poor as adults, and more likely to have children with poorer health outcomes over the course of their lives than children born to older mothers.³

WHAT OTHER DATA DO WE NEED?

- Data to identify gaps in community services
- Data that helps providers better understand utilization of services

WHAT COULD WORK TO TURN THE CURVE?

- Increase access to educational programs for youth in juvenile justice and foster care to provide education about pregnancy and sexually transmitted infections (STIs)
- Increase payer coverage of post-partum long-acting contraception
- Increase same day access to a full array of contraceptive options in health care settings
- Make contraceptives available in educational facilities
- Require that sex education curricula contain medically accurate information
- Review school sex education policies to ensure they contain information on avoiding teen pregnancy and sexually transmitted infections

RECOMMENDED READING/LISTENING

The Pregnancy Risk Assessment Monitoring System (PRAMS): Overview of Design and Methodology.
<https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2018.304563>

NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
Helping Each Adolescent Reach Their Spark (H.E.A.R.T.S)	https://www.heartsnc.org/
NC DHHS Adolescent Pregnancy Prevention Program	https://www.teenpregnancy.ncdhhs.gov/appp.htm
NC DHHS Personal Responsibility Education Program (PREPare) for Success	https://www.teenpregnancy.ncdhhs.gov/prep.htm
North Carolina Area Health Education Centers (NC AHEC)	https://www.ncahec.net/healthy-north-carolina-2030/
North Carolina School Health Training Center (NCSHTC) - ECU	https://hhp.ecu.edu/ncshtc/
Nurse-Family Partnership	https://www.nursefamilypartnership.org/
Sexual Health Initiatives for Teens (SHIFT) NC - Gaston Youth Connected	https://www.shiftnc.org/initiatives/gaston-youth-connected
Teen Health Connection	https://teenhealthconnection.org/teens-and-tots/



STATE HEALTH IMPROVEMENT PLAN

HNC 2030 Indicators

CLINICAL CARE FACTORS

Uninsured.....	94-97
Primary Care Clinicians.....	98-103
Early Prenatal Care.....	104-107
Suicide Rate.....	108-110

WHAT RESULT DO WE WANT?

All people in North Carolina have access to comprehensive, high quality, affordable health insurance.

WHY IS THIS IMPORTANT?

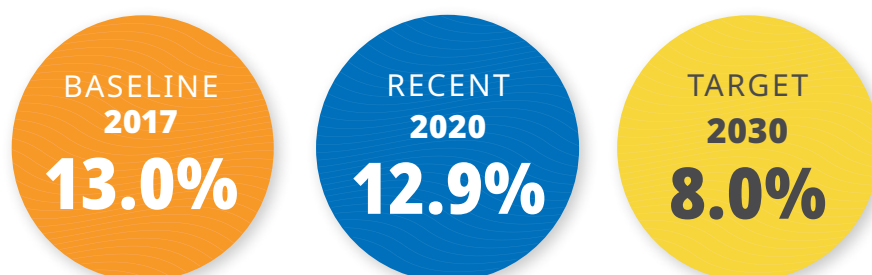
Access to quality health care services is critical to achieve and maintain health, prevent and manage disease, and achieve health equity. Lack of health insurance can make health care inaccessible and unaffordable.

HNC 2030 HEADLINE INDICATOR:

**Percent of the population
under age 65 without
health insurance**

WHAT DOES THIS INDICATOR MEASURE?

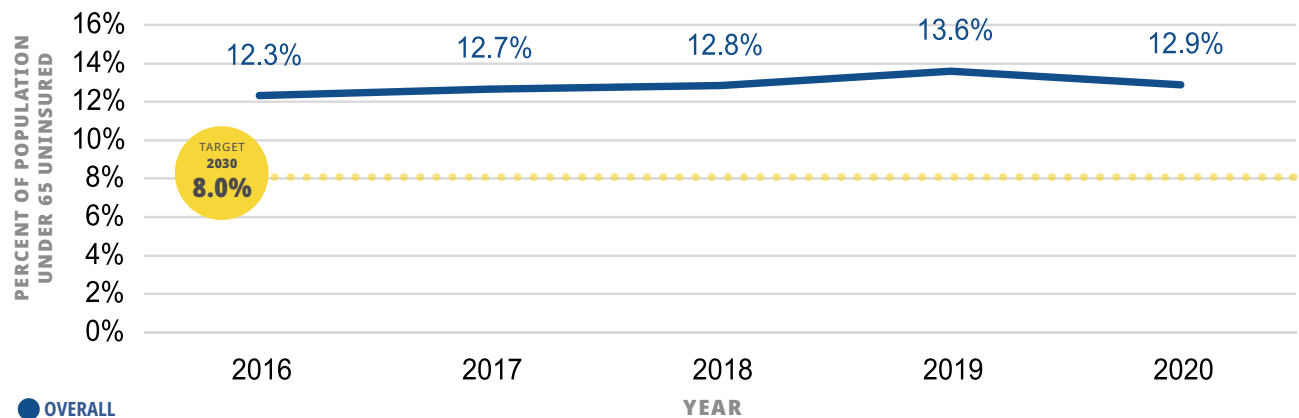
- Uses Small Area Health Insurance Estimates, reported annually by the U.S. Census Bureau
- Combines data from The American Community Survey (ACS), Demographic population estimates, aggregated federal tax returns, participation records for the Supplemental Nutrition Assistance Program (SNAP), county Business Patterns, Medicaid, Children's Health Insurance Program (CHIP) participation records, and the US Census
- Consistent estimates are available from 2008-2019
- Disaggregated by race, gender, income level, age group, and county
- Not all cross classifications are available

BASELINE DATA FROM HNC 2030**HOW ARE WE DOING?**

- Percent of population under the age of 65 with no insurance is relatively stable.
- Hispanic/Latinx people are the ethnic group most impacted.
- People at or below 200% of the Federal Poverty Level are five times more likely to not have insurance than people at 400% (and above Federal Poverty Level).

CURRENT DATA TRENDED OVER TIME

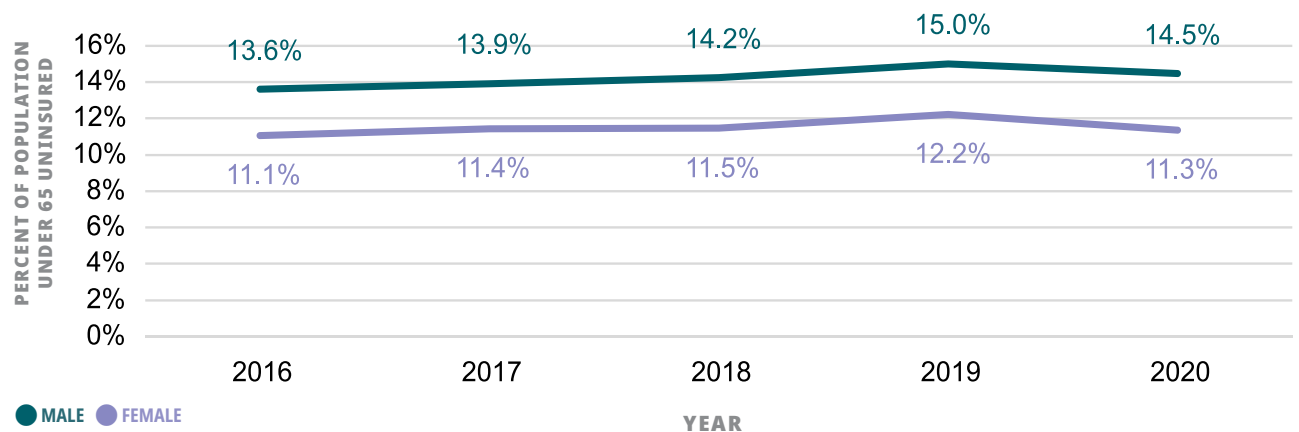
Figure 65. Percent of people under 65 with no insurance in North Carolina (2016 - 2020)



Data source: N.C. State Center for Health Statistics using the American Community Survey

Previously, Uninsured estimates used the Small Area Health Insurance Estimates (SAHIE), which used combined data including the American Community Survey (ACS). Because SAHIE data for 2020 is delayed due to the pandemic, these estimates use the ACS to provide estimates comparable for 2016-2020. Additionally, weights used for 2020 ACS estimates are considered experimental, as methodology had to be adjusted due to the pandemic.

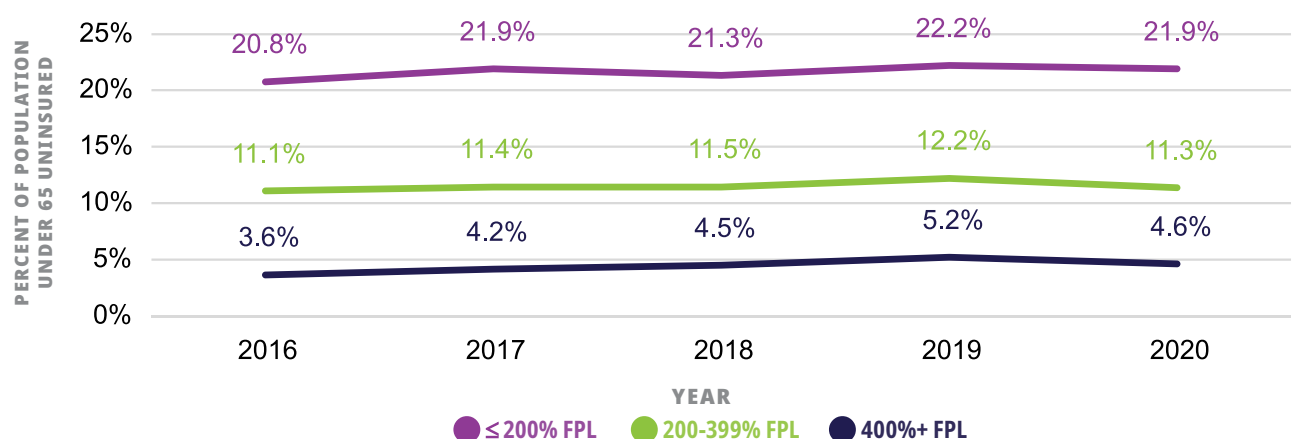
Figure 66. Percent of people under 65 with no insurance in North Carolina by gender (2016 - 2020)



Data source: N.C. State Center for Health Statistics using the American Community Survey

Previously, Uninsured estimates used the Small Area Health Insurance Estimates (SAHIE), which used combined data including the American Community Survey (ACS). Because SAHIE data for 2020 is delayed due to the pandemic, these estimates use the ACS to provide estimates comparable for 2016-2020. Additionally, weights used for 2020 ACS estimates are considered experimental, as methodology had to be adjusted due to the pandemic.

Figure 67. Percent of people under 65 with no insurance in North Carolina by poverty level (2016 - 2020)



Data source: N.C. State Center for Health Statistics using the American Community Survey

Previously, Uninsured estimates used the Small Area Health Insurance Estimates (SAHIE), which used combined data including the American Community Survey (ACS). Because SAHIE data for 2020 is delayed due to the pandemic, these estimates use the ACS to provide estimates comparable for 2016-2020. Additionally, weights used for 2020 ACS estimates are considered experimental, as methodology had to be adjusted due to the pandemic.

THE STORY BEHIND THE CURVE

The 2021 NC State Health Improvement Plan Community Council Meeting and Stakeholder Symposia stimulated dialogue among attendees. Questions that the participants posed included:

- Is healthcare a right?
- What is the standard for high quality health care? Is there a living document?
- What does high quality mean? Standards of care have been established.
- Who shares the responsibility?
- Who benefits from high quality healthcare?
- Does the government bail out insurance companies by giving a certain amount of care, but doesn't address root causes or families getting the care that they need?
- Who owns this issue in the state?
- Who were the community care givers? Are there enough of the other groups to meet the unmet need?
- Did the care of people fall to the community when we did not have health insurance 100 years ago?
- Does shared responsibility bring out the opportunity to do nothing?

2021 NC SHIP Stakeholder Symposia Participants

The same attendees expanded the story expanded about uninsured people with these collective statements:

- "People need information about the different levels of insurance within plans."
- "Many people do not qualify for the subsidies and fall into a coverage gap."
- "Because North Carolina has a robust safety net, there is a philosophical and political bias against support for Medicaid expansion."
- "The safety net is an excuse not to expand Medicaid."
- "We may need new words to describe the problems and the solutions to avoid the pitfalls of bias in our public discourse."
- "The terminology we use for the uninsured can be stigmatizing."
- "The undocumented population doesn't qualify for these services."
- "Implicit bias needs to be addressed to create change."
- "Paternal leave/care not offered by some employers."
- "Family care excludes father."

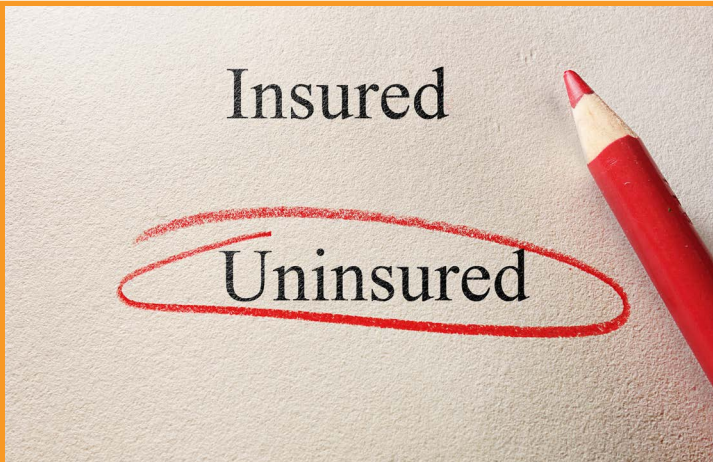
2021 NC SHIP Stakeholder Symposia Participants

WHAT OTHER DATA DO WE NEED?

- Impact of COVID-19 pandemic on employer sponsored insurance
- Estimates of underinsured/uninsured at the county level
- Major employer insurance benefits available in area
- Analysis of support/opposition by elected officials to Medicaid expansion
- Stories from consumers/residents and their experience
- Identify rural areas that have access to health care/health insurance
- Number of participants using ACA insurance and type of care they purchase
- Healthcare/health insurance access data from the Latino population

WHAT COULD WORK TO TURN THE CURVE?

- Determine need for more community health clinics by employing data analysts
- Expand community health workers to empower communities to ensure all individuals can access healthcare
- Expand Medicaid eligibility criteria
- Increase publicity and navigator funding to provide instruction and access for open enrollment
- Increase the number of bilingual healthcare and insurance providers and staff
- Leverage community benefit dollars from Medicaid Transformation to meet the needs of the uninsured
- Support bans or limitations on short-term health plans



RECOMMENDED READING/LISTENING

The Uninsured and the ACA: A Primer - Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act.
<https://www.kff.org/uninsured/report/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act/>

The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020.
<https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/>

NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
American Heart Association	https://www.heart.org/ https://www.heart.org/en/get-involved/advocate/federal-priorities/access-to-care
Care4Carolina	https://care4carolina.com/
Down Home North Carolina	https://downhomenc.org/
Equality North Carolina	https://equalitync.org/
Foundation for Health Leadership & Innovation (FHLI) - NC Oral Health Collaborative (NCOHC)	https://oralhealthnc.org/
Foundation for Health Leadership & Innovation (FHLI) - NC Rural Health Leadership Alliance (NCRHLA)	https://foundationhli.org/ncrhl/
Legal Aid of North Carolina	https://www.legalaidnc.org/about-us/projects/medical-legal-partnership
NC Child	https://ncchild.org/about-us/
NC DHHS Community Health Workers (CHW)	https://www.ncdhhs.gov/divisions/office-rural-health/community-health-workers
NC DHHS Office of Rural Health	https://www.ncdhhs.gov/divisions/orh
NC Rural Center	https://www.ncruralcenter.org/
North Carolina Association of Free & Charitable Clinics (NCAFCC) - Camino Clinic	https://ncafcc.org/our-clinics/camino-clinic/
North Carolina Association of Local Health Directors (NCALHD)	https://www.ncalhd.org/
North Carolina Community Health Center Association (NCCCHA)	https://www.ncchca.org/community-resources/policy-advocacy/nc-insurance-gap/ https://www.ncchca.org/community-resources/programs-services/outreach-enrollment-program/
North Carolina Healthcare Association (NCHA)	https://www.ncha.org/priority-issues/#state-priorities
North Carolina Justice Center	https://www.ncjustice.org/projects/health-advocacy-project/medicaid-expansion/uninsured-in-north-carolina/

WHAT RESULT DO WE WANT?

All people in North Carolina have access to comprehensive, high quality, affordable health care provided by clinicians who identify with the culture of people they serve.

WHY IS THIS IMPORTANT?

Having a primary care provider (PCP) is important for maintaining health and preventing and managing serious diseases. PCPs can develop long-term relationships with patients and coordinate care across health care providers. Strategies like team-based care and innovative payment methods are promising approaches for improving access to primary care.¹

HNC 2030 HEADLINE INDICATOR:
Number of NC counties with a primary care workforce to county population ratio of 1:1,500

Primary care workforce as a ratio of the number of full-time equivalent primary care clinicians

WHAT DOES THIS INDICATOR MEASURE?

This indicator is a measurement of geographic access to health care expressed as a ratio of clinician to population. Lower is better: 1:2000 is better than 1:4000. The HNC 2030 target is 1:1,500. The HNC 2030 target is 1500:1. Clinicians include primary care physicians, physician assistants, nurse practitioners, and certified nurse midwives.

Licensure data for clinicians in North Carolina is the *primary* data source. Clinicians are assigned to a county based on primary practice location:

- A primary care clinician is a physician or physician assistant practicing family medicine, general internal medicine, pediatrics, or obstetrics and gynecology
- A nurse practitioner must be certified in a primary care specialty, e.g., a family nurse practitioner and working in a primary care setting, e.g., not a hospital
- A certified nurse midwife working in a primary care setting, e.g., not a hospital

BASELINE DATA FROM HNC 2030

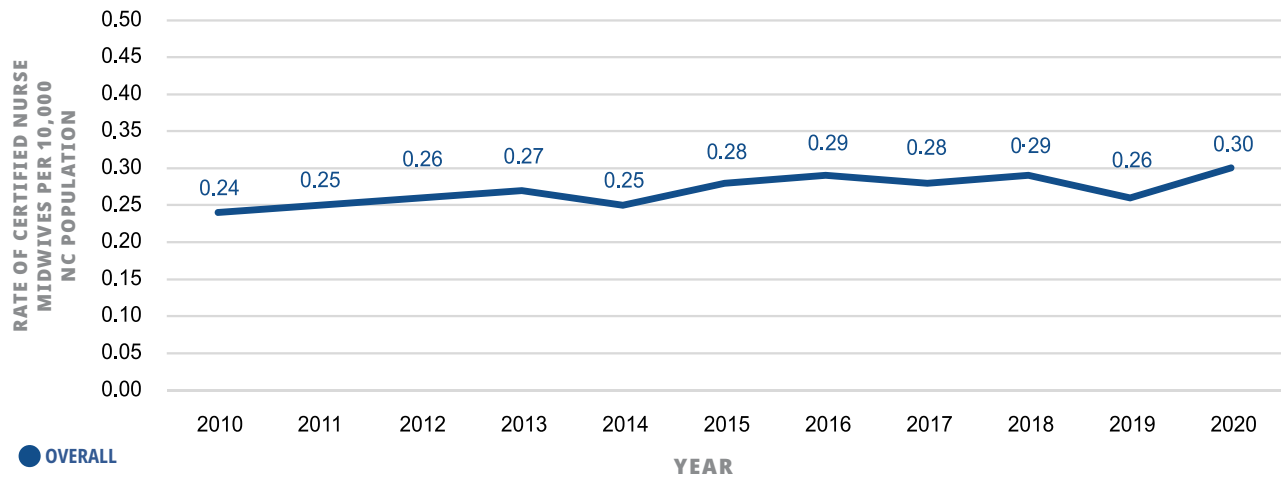


HOW ARE WE DOING?

- Distribution of primary care clinicians per county population remains constant since 2017.
- Over the last decade, there has been an increase in the number of underrepresented minority clinicians (Certified nurse midwives, nurse practitioners, and primary care physicians).
- Nurse practitioners have seen the greatest rate of increase among all types of primary care clinicians going from 3.8 (2010) to 8.1 (2020) per 10,000 population.

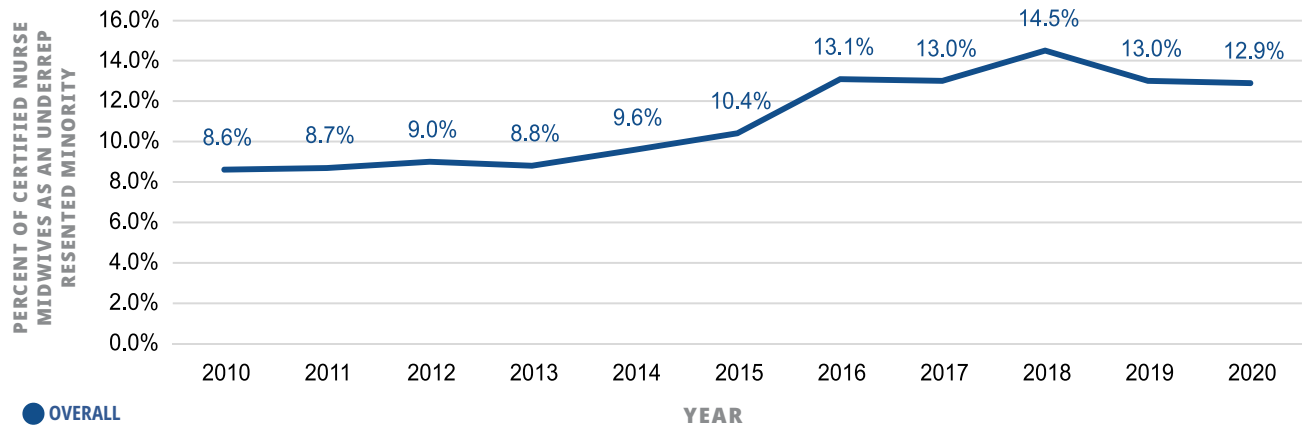
CURRENT DATA TRENDED OVER TIME

Figure 68. Certified nurse midwives in North Carolina (2010 - 2020)



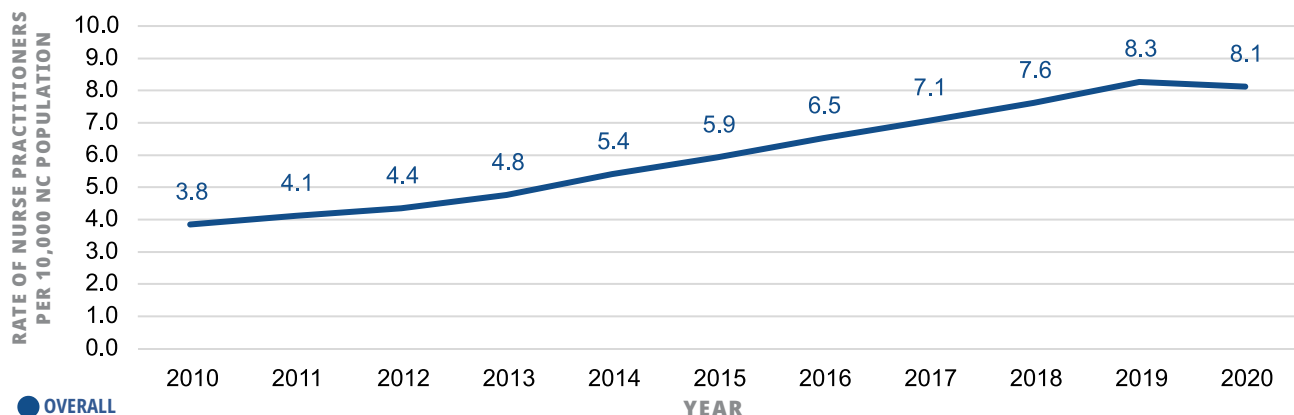
Data source: North Carolina Health Professions Data System, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Created December 27, 2021 at <https://nchealthworkforce.unc.edu/interface/supply/>.

Figure 69. Certified nurse midwives as an underrepresented minority in North Carolina (2010 - 2020)



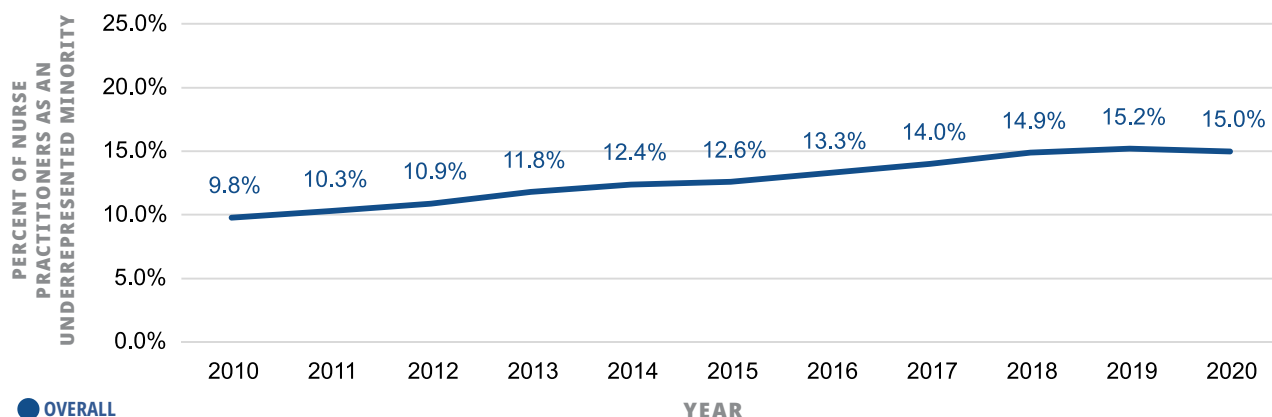
Data source: North Carolina Health Professions Data System, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Created December 27, 2021 at <https://nchealthworkforce.unc.edu/interface/supply/>.

Figure 70. Nurse practitioners in North Carolina (2010 - 2020)



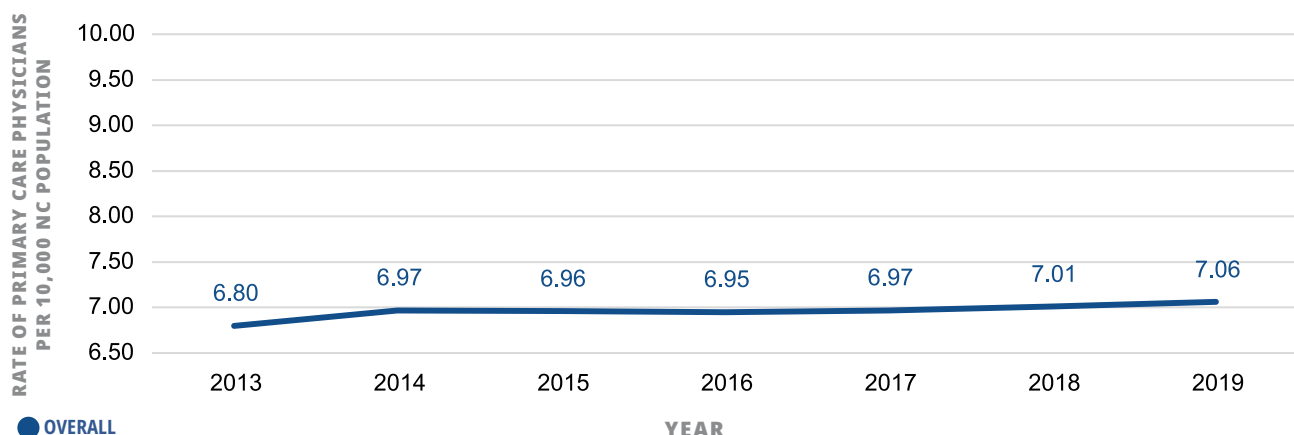
Data source: North Carolina Health Professions Data System, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Created December 27, 2021 at <https://nchealthworkforce.unc.edu/interace/supply/>.

Figure 71. Nurse practitioners as an underrepresented minority in North Carolina (2010 - 2020)



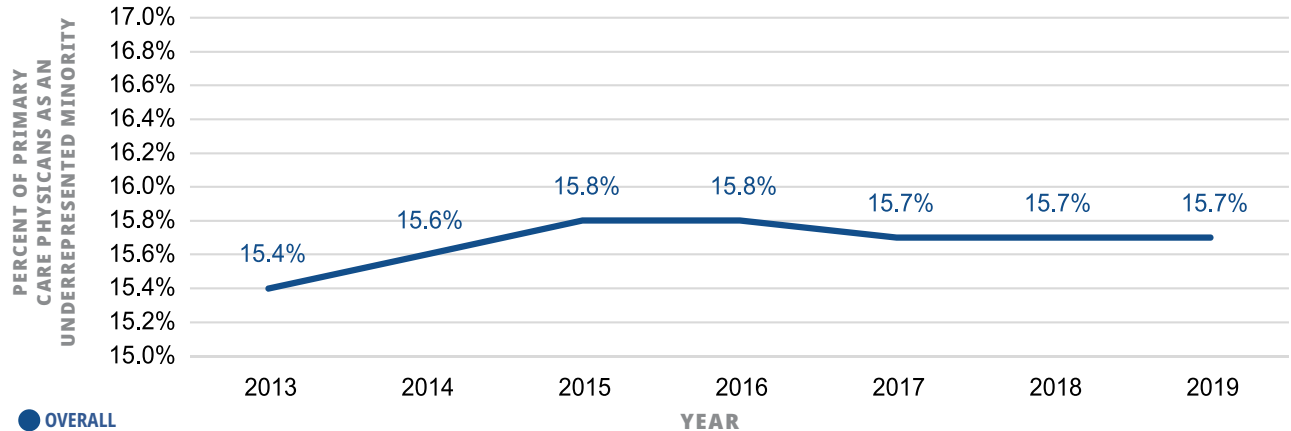
Data source: North Carolina Health Professions Data System, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Created December 27, 2021 at <https://nchealthworkforce.unc.edu/interace/supply/>.

Figure 72. Primary care physicians in North Carolina (2013 - 2019)



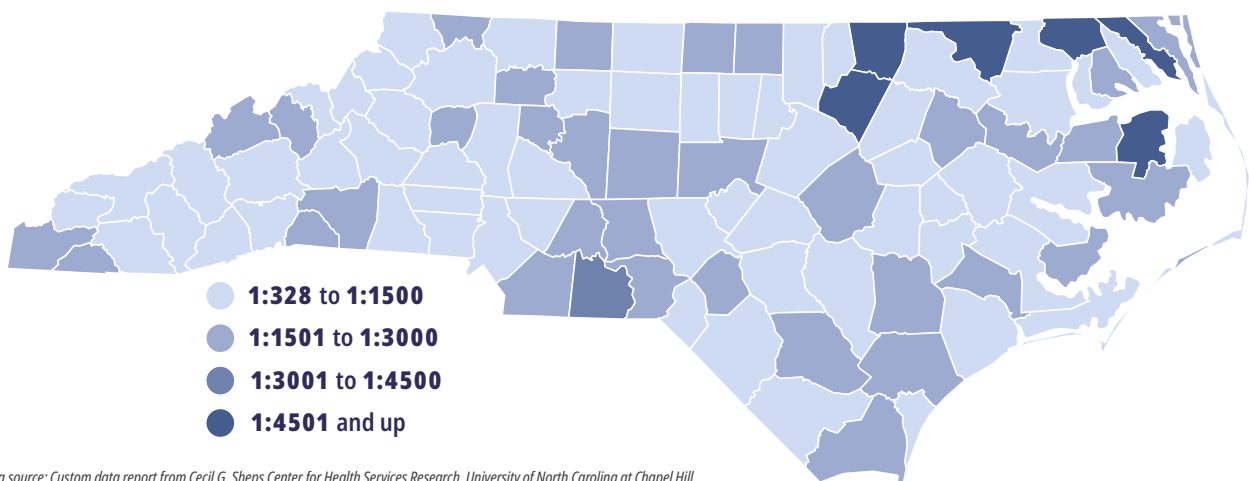
Data source: North Carolina Health Professions Data System, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Created December 27, 2021 at <https://nchealthworkforce.unc.edu/interace/supply/>.

Figure 73. Primary care physicians as an underrepresented minority in North Carolina (2013 - 2019)



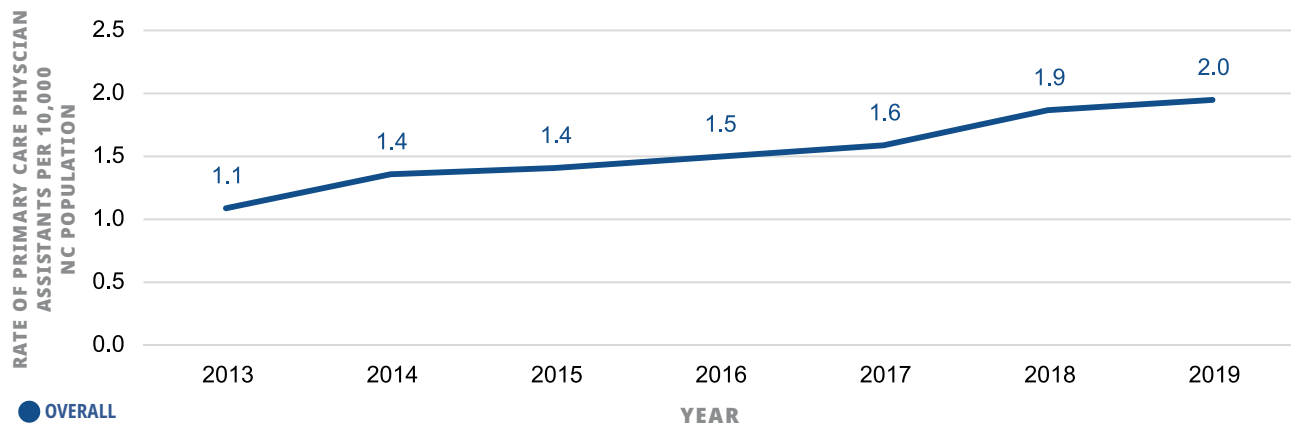
Data source: North Carolina Health Professions Data System, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Created December 27, 2021 at <https://nchealthworkforce.unc.edu/interface/supply/>.

Figure 74. Population per primary care clinician in North Carolina (2019)



Data source: Custom data report from Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

Figure 75. Physician assistants with primary practice listed as primary care in North Carolina (2013 - 2019)



Data source: North Carolina Health Professions Data System, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Created December 27, 2021 at <https://nchealthworkforce.unc.edu/interface/supply/>.

THE STORY BEHIND THE CURVE

Access to health services means “the timely use of personal health services to achieve the best health outcomes.” A lack of access to care can impact overall physical, social, and mental health. It can also affect someone’s quality of life and livelihood. Barriers to access typically include the high cost of care, inadequate or no insurance coverage, and a lack of available services (geographically or remotely), especially culturally competent care. These barriers can lead to unmet health needs, delays in receiving appropriate care, an inability to get preventive services, preventable hospitalizations, and financial burdens. Access to care often varies by race/ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location.

Source: Healthy People 2030 Access to Health Services Workgroup

Participants in the 2021 NC SHIP Community Council Meeting and Stakeholder Symposia elaborated on the story of primary care in North Carolina with these comments:

- “Surprising that certified nurse midwives (CNMs) are weighted at 0.75 in primary care when an obstetrician (OB) is weighted at 0.25 and most CNMs work in OB.”
- “To the point regarding CNM vs OBs time splitting: CNMs do mostly deliveries, OB visits, and prescribing birth control, and annual exams are all primary care activities. OBs are mostly surgical so actually, we under-valued CNMs in this regard.”
- “The correlation of good health outcomes in quality primary care is the level of continuity and comprehensiveness – it’s the longitudinal relationship and the understanding of all of the indicators and factors putting the puzzle together.”
- “We have a data problem in counting population per primary care practitioner – example in Chatham Co. Most of the physicians that work in Northern Chatham Co., have a primary practice in Orange County, but their ambulatory office may be in Chatham County.”
- “There are primary care physicians that have practices in one county, but they may go out to surrounding counties three days per week but are not counted in those counties.”
- “I am willing to accept that the data is not perfect and that this is all that we have, but it is bothersome that there is no sense of “part-time-edom”. Most physicians in academic health settings are going to be less than one half clinical. In addition, you have people in various stages of retirement or family life cycle. This is a big impact on access that we have no way to estimate.”
- “This is also an AWESOME measure because it now includes advanced practice providers whereas previously it only captured primary care physicians. This is a huge advance and is really appreciated. No doubt it can still be refined but it is still a great advance from what we had been using.”

WHAT OTHER DATA DO WE NEED?

- Stories from consumers/residents and their experiences around access to primary care in their community
- Contact information for all health care providers
- Number and experience of people who reside in North Carolina but seek health care in neighboring states
- Map safety net service availability and gaps including primary care, prenatal/postnatal care, dental, and behavioral health care
- Telehealth availability

WHAT COULD WORK TO TURN THE CURVE?

- Assess recruitment strategies used by colleges and universities that focus on rural needs
- Develop long-term solutions to healthcare workforce challenges with emphasis on increasing the number of North Carolina health care providers from historically marginalized populations
- Ensure highspeed internet access to support access to telehealth, electronic health records and controlled substance reporting system sites
- Expand Medicaid to support financial viability of primary care providers serving low-income patients
- Expand medical school training and learning experiences focused on the skills necessary to practice successfully in rural areas
- Grow NCCARE360 by adding more health systems, payers, providers
- Increase patient access and provide for adequate compensation for consultations with specialists
- Increase requirement for number of rural health clinical rotations for physician assistants (PAs) and Advanced Practice Nurses (APNs)
- Increase telehealth primary care initiatives in rural areas
- Increase the number of residency positions in rural areas
- Invest in rural economies
- Review and optimize middle and high school career and tutoring programs to augment math and science skills
- Support increased funding for provider loan repayment programs that incentivize primary care providers to practice in medically underserved areas
- Support pipeline programs in rural areas to encourage high school and college students to pursue careers in medicine and primary care



RECOMMENDED READING/LISTENING

NC Health Info: Empowering Your Health Care Decisions.
<https://www.nchealthinfo.org/providers-services/>

NC Medicaid/Health Choice Primary Care Providers.
<https://medicaid.ncdhhs.gov/documents/medicaid-health-choice-primary-care-providers>

NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
College Foundation of North Carolina (CFNC)	https://www.cfnc.org/
Community Care of North Carolina (CCNC)	https://www.communitycarenc.org/
Duke Health's Primary Care Preceptor Development Mini-Fellowship Program	https://fmch.duke.edu/education-training/primary-care-preceptor-development-mini-fellowship
Mountain Area Health Education Center (MAHEC)	https://mahec.net/
Mountain Community Health Partnership (MCHP)	https://www.mchp.care/
NC DHHS Office of Rural Health	https://www.ncdhhs.gov/divisions/orh
NC Medical Society	https://www.ncmedsoc.org/
North Carolina Academy of Physician Assistants (NCAPA)	http://ncapa.org/
North Carolina Alliance for Health Professions Diversity (NCAHPD)	https://ncahpd.org/
North Carolina Area Health Education Centers (NC AHEC)	https://www.ncahec.net/healthy-north-carolina-2030/
North Carolina Association of Free & Charitable Clinics (NCAFCC)	https://ncafcc.org/
North Carolina Association of Local Health Directors (NCALHD)	https://www.ncalhd.org/
North Carolina Community Health Center Association (NCCHCA)	https://www.ncchca.org/
North Carolina Healthcare Association (NCHA)	https://www.ncha.org/
North Carolina Health Occupations Students of America (NC HOSA)	http://nchosa.org/
North Carolina Institute of Medicine (NCIOM)	https://nciom.org/
North Carolina Medical Board	https://www.ncmedboard.org/
North Carolina Public Health Association (NCPHA)	https://ncpha.memberclicks.net/
North Carolina Nurses Association (NCNA)	https://www.ncnurses.org/
North Carolina Pediatric Society (NCPeds)	https://www.ncpeds.org/
Office of Rural Initiatives at UNC	https://www.med.unc.edu/inclusion/ori/
Primary Care Advisory Committee (PCAC) Office of Rural Health	https://nosorh.org/6-promising-practice-nc-office-of-rural-health-helps-rural-providers-get-connected-to-hit/
The Cecil G. Sheps Center for Health Services Research at UNC	https://www.shepscenter.unc.edu/

WHAT RESULT DO WE WANT?

All birthing people have healthy pregnancies and maternal birth outcomes.

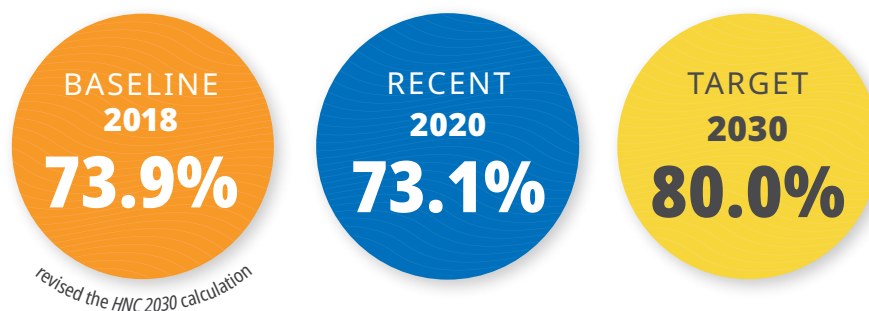
WHY IS THIS IMPORTANT?

Prenatal or antepartum care is care given to pregnant women by an obstetrician or midwife and increases the likelihood of a safe and healthy delivery. Components of prenatal care recommended by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) include determination of gestational age, fetal ultrasound imaging, routine laboratory testing, immunizations, genetic screening, psychosocial risk screening and patient education. According to the National Institute of Health, engaging in prenatal care early and consistently in pregnancy is an essential preventative factor in reducing adverse pregnancy outcomes such as low birth weight.¹ By addressing chronic diseases such as diabetes and hypertension associated with preterm birth, prenatal care has been found to reduce adverse birth outcomes. Assessment of prenatal care utilization is considered a critical step in improving prenatal care access and birth outcomes.^{2,3}

HNC 2030 HEADLINE INDICATOR:
Percent of women who receive pregnancy-related health care services during the first trimester of a pregnancy

WHAT DOES THIS INDICATOR MEASURE?

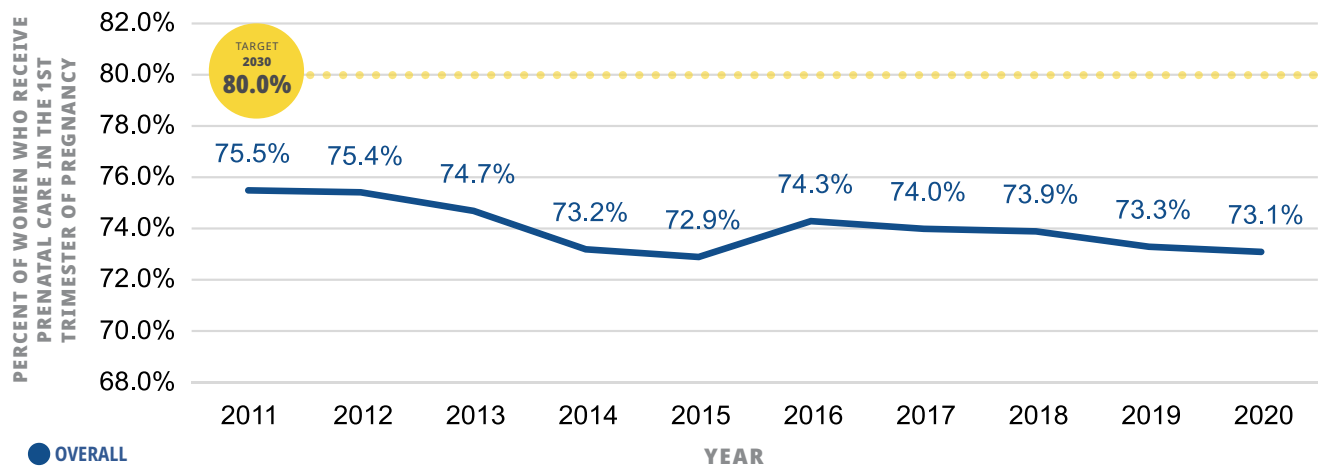
This is a calculated variable based on the difference between the date of last menses and prenatal care initiation. The indicator uses vital records birth certificate data, providing both frequencies and percentages.

BASELINE DATA FROM HNC 2030**HOW ARE WE DOING?**

- The HNC 2030 target is 80.0% of women will receive care in the first trimester of pregnancy.
- The percent of women receiving care in the first trimester of pregnancy is trending downward.
- Hispanic/Latinx women (62.9%) and Black/African American women (66.1%) have lower percentages of early prenatal care than White/Caucasian women (79.8%).

CURRENT DATA TRENDED OVER TIME

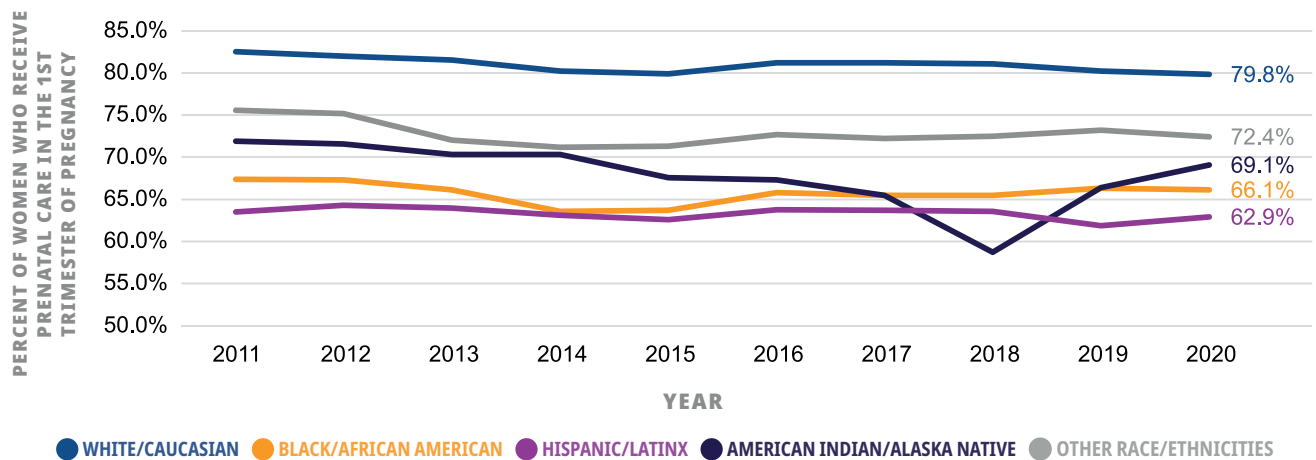
Figure 76. Early prenatal care use across populations in North Carolina (2011 - 2020)



Data source: N.C. State Center for Health Statistics, Vital Statistics.

The month prenatal care began is based on the date of the first prenatal care visit, date of birth, and the obstetric estimate of gestational age. Prior published N.C. State Center for Health Statistics reports have used the same calculation but used a calculated estimate of gestational age. To stay consistent with the National Center for Health Statistics we are now using the obstetric estimate in our publications and the prenatal care month calculation, which accounts for differences in prior published reports.

Figure 77. Early prenatal care use in North Carolina by race/ethnicity (2011 - 2020)



Data source: N.C. State Center for Health Statistics, Vital Statistics.

The month prenatal care began is based on the date of the first prenatal care visit, date of birth, and the obstetric estimate of gestational age. Prior published N.C. State Center for Health Statistics reports have used the same calculation but used a calculated estimate of gestational age. To stay consistent with the National Center for Health Statistics we are now using the obstetric estimate in our publications and the prenatal care month calculation, which accounts for differences in prior published reports.

THE STORY BEHIND THE CURVE

Racial discrimination is a significant risk factor for adverse birth outcomes. To best understand the mechanisms by which racial discrimination impacts birth outcomes, and to inform the development of effective interventions that eliminate its harmful effects on health, longitudinal research that incorporates comprehensive measures of racial discrimination is needed. Health care providers must fully acknowledge and address the psychosocial factors that impact health outcomes in minority racial/ethnic women.⁴

WHAT OTHER DATA DO WE NEED?

- Number of pregnancy care providers in the community
- Number of high-risk pregnancy care providers in the community
- Employer policies related to pregnancy care
- Number of community health care workers providing outreach and education
- Availability of public transportation to get to prenatal appointments

WHAT COULD WORK TO TURN THE CURVE?

- Allow certified nurse midwives to practice under their full authority
- Expand Medicaid eligibility
- Expand safe and reliable public transit options
- Provide group prenatal care, childbirth education, and doula services as covered services by Medicaid
- Strengthen workforce diversity and cultural humility in the delivery of prenatal care services
- Use community health workers to provide outreach and education to women of childbearing age in underserved communities
- Utilize the Children's Health Insurance Program option to provide coverage for comprehensive prenatal care to undocumented immigrant women

RECOMMENDED READING/LISTENING

Insurance Differences in Preventive Care Use and Pregnant Women in a Medicaid Nonexpansion State: A Retrospective Cohort Study.
<https://pubmed.ncbi.nlm.nih.gov/31397625/>

Medicaid Expansion Improves Pregnancy Outcomes for Low-income Women.
<https://www.openaccessgovernment.org/pregnancy-outcomes/102698/>

NC Maternal Mental Health Matters.
<https://www.med.unc.edu/ncmatters/>

Workshop on Advancing Maternal Health Equity and Reducing Maternal Mortality.
<https://www.nationalacademies.org/event/06-07-2021/workshop-on-advancing-maternal-health-equity-and-reducing-maternal-mortality>



NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
Alliance of Black Doulas for Black Mamas	https://www.alliance-bdbm.com/
Maternal Support Services Baby Love Program	https://medicaid.ncdhhs.gov/beneficiaries/get-started/find-programs-and-services/maternal-support-services-baby-love-program
Care Management for High-Risk Pregnancies (CMHRP)	https://medicaid.ncdhhs.gov/transformation/care-management/care-management-high-risk-pregnancies-cmhrp
Community Care of North Carolina (CCNC) - Pregnancy Medical Home	https://www.communitycarenc.org/what-we-do/clinical-programs/pregnancy-medical-home
Count the Kicks	https://countthekicks.org/
Equity Before Birth	https://www.equitybeforebirth.com/
Federally Qualified Health Centers (FQHC)	https://medicaid.ncdhhs.gov/providers/programs-services/medical/federally-qualified-health-centers
Healthy Blue- Cityblock Health	https://www.fiercehealthcare.com/payer/cityblock-health-teams-up-blue-cross-nc-to-serve-medicaid-ma-patients-north-carolina
Health Equity and Racism (H.E.R.) LAB	https://www.herlab.org/
March of Dimes - NC Chapter	https://www.marchofdimes.org/pregnancy/prenatal-care.aspx#
NC Child	https://ncchild.org/
NC DHHS Healthy Opportunities	https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities
NC Maternal Mental Health MATTERS (Making Access to Treatment, Evaluation, Resources, and Screening Better)	https://www.med.unc.edu/ncmatters/
North Carolina Area Health Education Centers (NC AHEC)	https://www.ncahec.net/healthy-north-carolina-2030/
North Carolina Community Health Center Association (NCCHCA)	https://www.ncchca.org/
North Carolina Perinatal Health Strategic Plan	https://whb.ncpublichealth.com/phsp/
MomsRising	https://www.momsrising.org/
Perinatal Quality Collaborative of North Carolina (PQCNC)	https://www.pqcnc.org/
Planned Parenthood	https://www.plannedparenthood.org/health-center/north-carolina/raleigh/27603/raleigh-health-center-3338-90860?gclid=CjwKCAiAp8iMBhAqEiwAJb94zxOb9wekSKusZ8vrSvTz-3s0E5QScCUNqEr0NqBYOaxLHtQ0b7TWXBoCBqkQAvD_BwE
Postpartum Support International - North Carolina Chapter	https://psichapters.com/nc/
The UNC Center of Excellence in Maternal and Child Health Education, Science, and Practice	https://sph.unc.edu/mch/center-of-excellence/
UNC Collaborative for Maternal and Infant Health	https://www.mombaby.org/

WHAT RESULT DO WE WANT?

All people in North Carolina live in communities that foster and support positive mental health.

WHY IS THIS IMPORTANT?

Suicide rates increased 30% between 2000-2018 and declined in 2019 and 2020. Suicide is a leading cause of death in the United States, with 45,979 deaths in 2020. This is about one death every 11 minutes. The number of people who think about or attempt suicide is even higher. In 2020, an estimated 12.2 million American adults seriously thought about suicide, 3.2 million planned a suicide attempt, and 1.2 million attempted suicide. In 2020, suicide was among the top 9 leading causes of death for people ages 10-64. Suicide was the second leading cause of death for people ages 10-14 and 25-34.^{1,2}

HNC 2030 HEADLINE INDICATOR:

**Suicide rate per
100,000 people**
(Age-adjusted number of
deaths attributable to
self-harm per 100,000)

WHAT DOES THIS INDICATOR MEASURE?

N.C. Vital Records receives and files death certificates. The State Center for Health Statistics compiles, cleans, and publishes the death data. Finalized death data is only available 9-18 months after a year has ended. Accuracy of the underlying cause of death depends, to some extent, on the person making the determination and filing the death certificate.

The U.S. Census Bureau conducts decennial population census of the country, as well as yearly bridged population updates that estimate yearly population changes.

BASELINE DATA FROM HNC 2030**HOW ARE WE DOING?**

- Deaths from self-harm are highest among White/Caucasians.
- Suicide rate is approximately two-and-a half times higher in males than females.

CURRENT DATA TRENDED OVER TIME

Figure 78. Suicide rate in North Carolina (2010 - 2020)

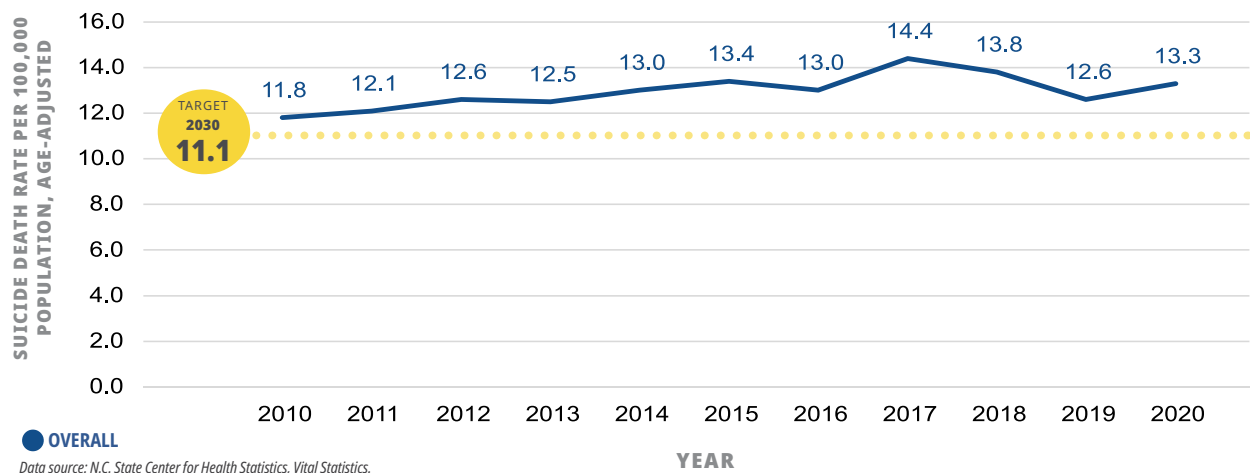


Figure 79. Suicide rate in North Carolina by race/ethnicity (2010 - 2020)

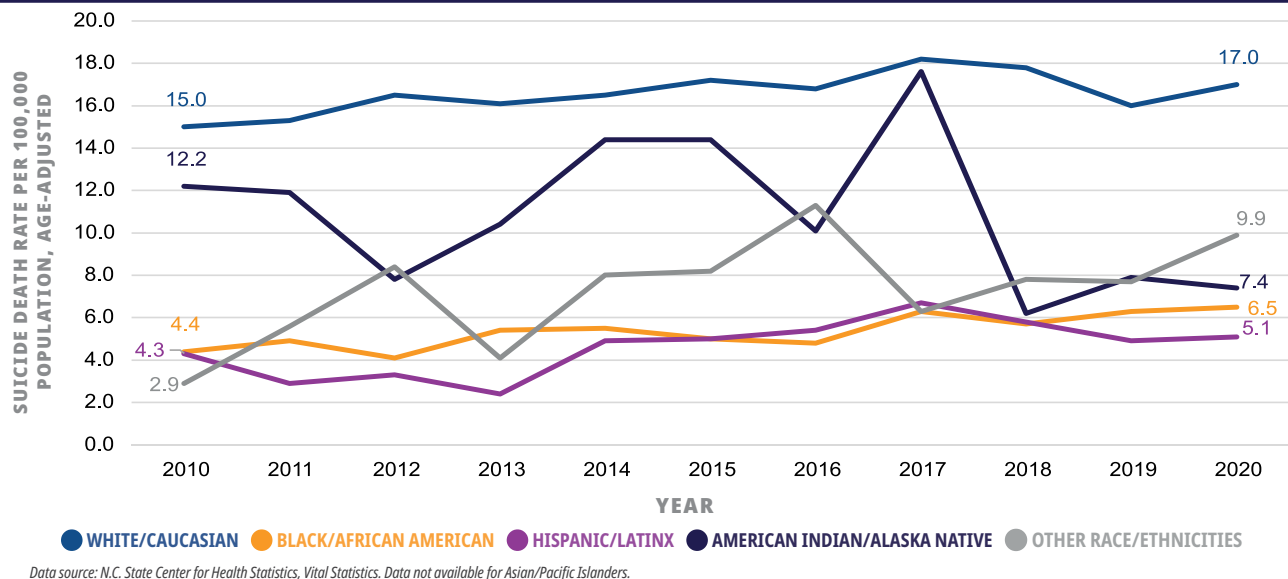
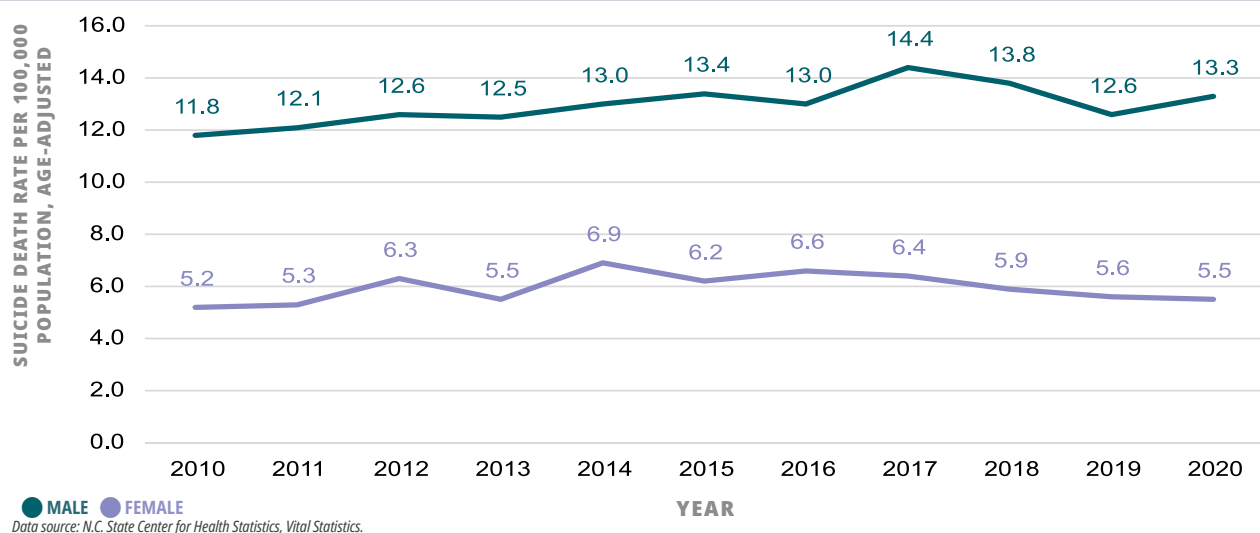


Figure 80. Suicide rate in North Carolina by gender (2010 - 2020)



THE STORY BEHIND THE CURVE

Some groups have higher suicide rates than others. Suicide rates vary by race/ethnicity, age, and other factors, such as where someone lives. By race/ethnicity, the groups with the highest rates were non-Hispanic American Indian/Alaska Native and non-Hispanic White populations. Other Americans with higher than average rates of suicide are veterans, people who live in rural areas, and workers in certain industries and occupations like mining and construction. Young people who identify as lesbian, gay, or bisexual have higher rates of suicidal thoughts and behavior compared to their peers who identify as heterosexual.^{3,4,5}

WHAT OTHER DATA DO WE NEED?

- Undiagnosed, untreated, mental health needs
- Occupations associated with higher risks of suicide
- Suicide ideation/attempts
- Coding proficiency among physicians, funeral home directors, medical examiners, and coroners
- Self-harm data
- Effectiveness of crisis response

WHAT COULD WORK TO TURN THE CURVE?

- Create safety nets for people that are unemployed or laid off from work
- Create trauma-informed schools with access to mental health providers
- Expand access to telemental health service
- Expand Medicaid eligibility criteria to increase access to mental health services
- Expand rapid access to crisis services, including implementing the national 988 number
- Implement policies targeted to decrease access to lethal means
- Improve access to maternal mental health services
- Improve access to social services and other supports
- Increase programs that provide mental health services and support for LGBTQ youth
- Increase programs that provide mental health services and support for military veterans
- Increase the use of universal screenings for perinatal mood/anxiety disorder
- Support the integration of physical and mental health

RECOMMENDED READING/LISTENING

2015 North Carolina Suicide Prevention Plan.

<https://injuryfreenc.dph.ncdhhs.gov/preventionResources/docs/2015-NC-SuicidePreventionPlan-2015-0505-FINAL.pdf>

Preventing Suicide: A Technical Package of Policy, Programs, and Practices.

<https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf>

NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
American Foundation for Suicide Prevention- North Carolina Chapter	https://afsp.org/chapter/north-carolina
Carolinas CARE Partnership	https://www.carolinascare.org/what-we-do/mental-health/
Faith Connections on Mental Illness	https://www.faithconnectionsonmentalillness.org/
National Alliance on Mental Illness - North Carolina Chapter	https://naminc.org/
North Carolina Area Health Education Centers (NC AHEC)	https://www.ncahec.net/healthy-north-carolina-2030/
North Carolina Governor's Challenge to Prevent Suicide	https://challenge.ncgwg.org/
UCLA-Duke Center for Trauma-Informed Suicide, Self-Harm & Substance Abuse Treatment & Prevention ASAP Center	https://asapnctsn.org/



STATE HEALTH IMPROVEMENT PLAN

HNC 2030 Indicators

HEALTH OUTCOMES

Infant Mortality.....	112-115
Life Expectancy.....	116-119

WHAT RESULT DO WE WANT?

All babies in North Carolina are born healthy, thrive in caring and healthy homes, and see their first birthday.

WHY IS THIS IMPORTANT?

Infant mortality is considered a key indicator of the overall health of the population, and both infant and maternal mortality are multifaceted problems impacted by factors such as access to care, poverty, systemic racism, and housing.¹

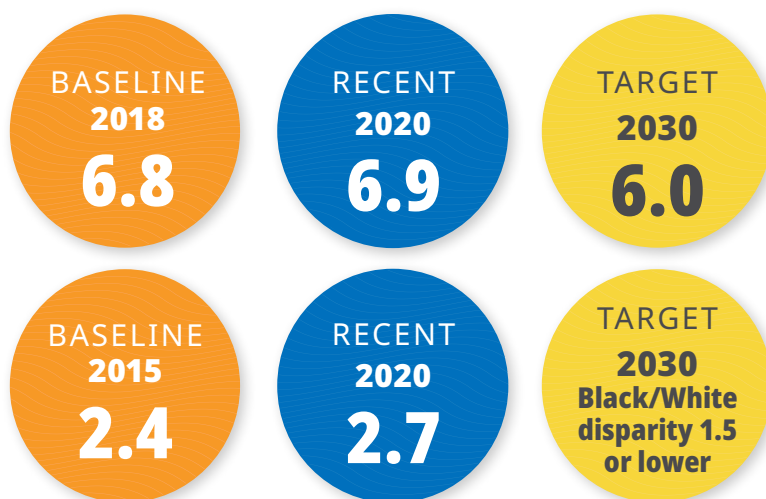
Racial disparities have long plagued the state's infant mortality rate and many other health indicators, now including those associated with the current pandemic. And at the same time, as with COVID-19, we know how to prevent many infant deaths. Other states have prioritized addressing racial gaps in infant deaths and have moved to expand Medicaid, address the impacts of racism on birth outcomes, and implement a number of policies that improve family economic security. Here in North Carolina, it is beyond time to implement critical policy interventions that we already know will work to prevent unnecessary infant deaths.²

HNC 2030 HEADLINE INDICATOR:

**Rate of infant births
per 1,000 live births**

WHAT DOES THIS INDICATOR MEASURE?

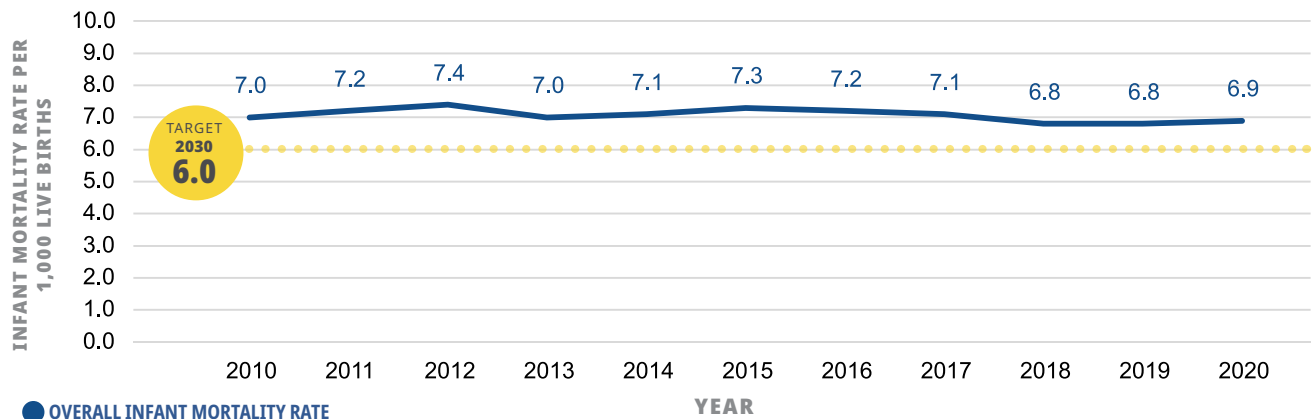
- The data are produced annually using counts of resident birth certificate data and death Certificate data.
- The disparity ratio indicator is a ratio of the non-Hispanic black to the non-Hispanic White infant mortality rates, calculated by aggregating five years of data.

BASELINE DATA FROM HNC 2030**HOW ARE WE DOING?**

- The HNC 2030 target for infant mortality rate is 6.0 per 1,000 live births.
- Black/African Americans experience over two and a half times more infant deaths than White/Caucasians.
- Infant mortality rates have been relatively stable for the last decade.

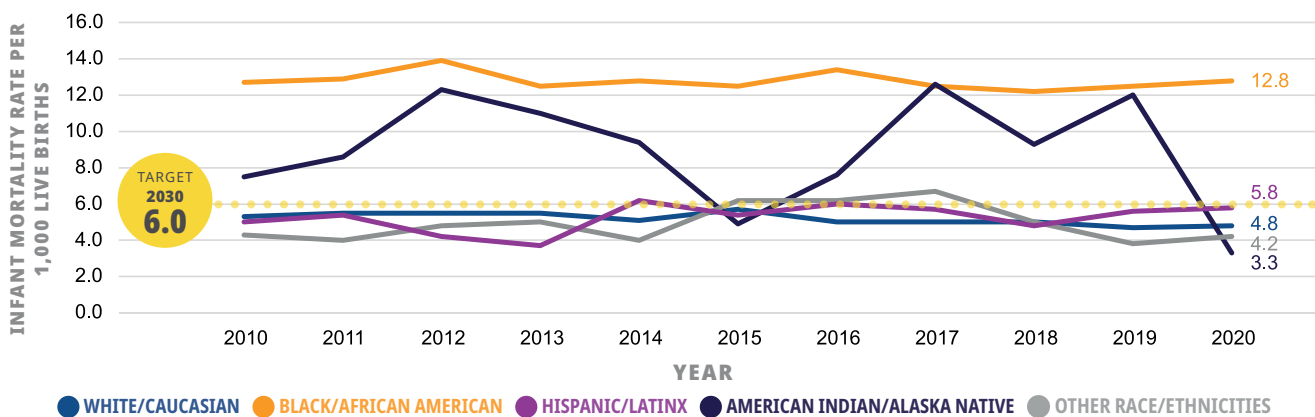
CURRENT DATA TRENDED OVER TIME

Figure 81. Infant mortality rate in North Carolina (2010 - 2020)



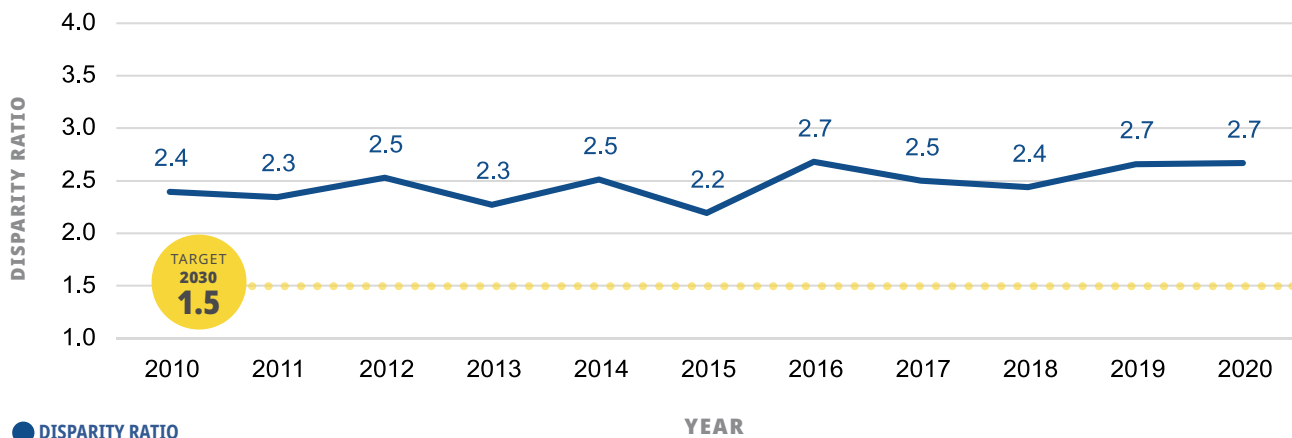
Data source: N.C. State Center for Health Statistics, Vital Statistics.

Figure 82. Infant mortality rate in North Carolina by race/ethnicity (2010 - 2020)



Data source: N.C. State Center for Health Statistics, Vital Statistics. Data not available for Asian/Pacific Islanders.

Figure 83. Infant mortality disparity ratio between Black/African Americans and White/Caucasians in North Carolina (2010 - 2020)



Data source: N.C. State Center for Health Statistics, Vital Statistics.

THE STORY BEHIND THE CURVE

Participants in the 2021 NC SHIP Community Council Meeting and Symposia expressed the following thoughts about infant mortality:

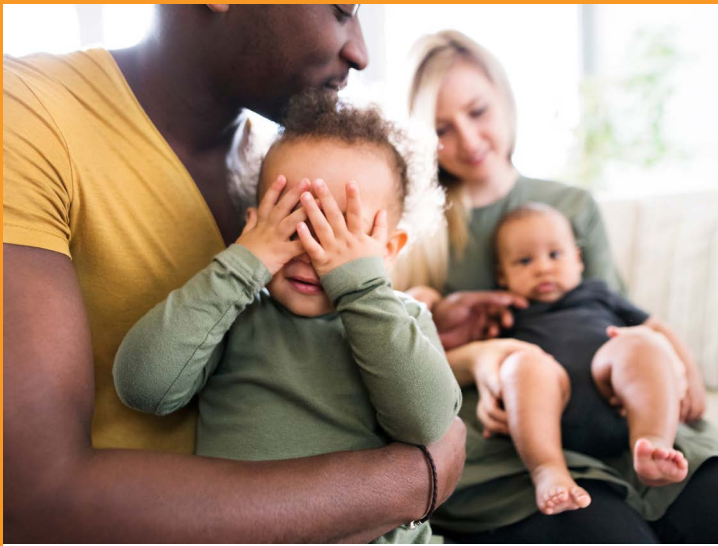
- “It’s hard to understand the root causes.”
- “Physiological stress due to racism, adverse childhood experiences, and social determinants play a huge role.”
- “Many children who died in the first year of life had no father listed on the birth certificate.”
- “The father’s name not being on the birth certificate may be an important predictor of risk – what does it mean? Is there economic, emotional stress?”
- “There are barriers to getting the father added: access to notary, transportation, affidavit of parentage is not easily found, cost of DNA test.”
- “Indicator rates for fertility suffer from small counts. Rates are sensitive with small counts and should be interpreted with caution. How do we navigate issues of equity if we can’t measure with small numbers?”
- “We need attorneys that understand statutes for adding father to the birth certificate.”

WHAT OTHER DATA DO WE NEED?

- Demographic profile of teens in community
- Number of middle and high schools
- Location of contraceptive health services (public and private)
- Number/map of organizations in community that have similar interest in teens and reproductive health
- Number/map of youth-serving businesses
- Estimate of number of pregnancies prevented
- Availability/utilization of services adjusted by the demographic rates
- Inventory of issues/challenges affecting access to services

WHAT COULD WORK TO TURN THE CURVE?

- Adopt national maternal and infant risk-appropriate Levels of Care Standards
- Allow pharmacists to dispense oral and transdermal hormonal contraceptives
- Expand efforts to prevent infant deaths related to unsafe sleep environments
- Improve access to, and use of, prenatal care, including Centering Pregnancy Programs, group prenatal care, evidence-based home visiting programs, and doula services
- Improve pre-conception routine medical check-ups and family planning counseling
- Include cultural and linguistic competency in preconception routine medical checkups and reproductive life planning so all babies see their first birthday
- Increase access to health insurance
- Increase access to smoking cessation, obesity and diabetes prevention, and alcohol use programs to women of reproductive age and to pregnant people
- Increase businesses, faith entities, and public buildings that qualify as breastfeeding friendly, and normalize breastfeeding in public spaces
- Support training on health equity including implicit bias and determinants of health
- Utilize the Children’s Health Insurance Program option to provide coverage for comprehensive prenatal care to undocumented immigrant women



“WEATHERING, DEFINED AS THE LIVED EXPERIENCE OF BLACK WOMEN (TOXIC STRESS), PUTS MOTHER AND CHILD AT RISK FOR NEGATIVE BIRTH OUTCOMES.”

- 2021 NC SHIP Community Council participant

RECOMMENDED READING/LISTENING

Maternal and Infant Mortality in North Carolina.
<https://www.ncmedicaljournal.com/content/ncm/82/3/191.full.pdf>

Title V Maternal and Child Health (MCH) Block Grant.
<https://mchb.hrsa.gov/programs-impact/title-v-maternal-child-health-mch-block-grant>

NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
Family Connects International	https://familyconnects.org/
Frank Porter Graham Child Development Institute	https://fpg.unc.edu/
March of Dimes- NC Chapter	https://www.marchofdimes.org/state-advocacy/state-advocacy-priorities-and-wins-NC.aspx
National Birth Equity Collaborative (NBEC)	https://birthequity.org/
NC Breastfeeding Coalition	https://www.ncbfc.org/
NC Child	https://ncchild.org/
NC DHHS Office of Minority Health and Health Disparities	https://www.ncminorityhealth.org/
NC Obstetrical and Gynecological Society	https://www2.ncmedsoc.org/nc-obstetrical-and-gynecological-society
North Carolina Midwifery Education, Regulation, and Association (MERA)	https://www.ncmera.org/
Smart Start- Home Visiting & Parenting Education System-Building	https://www.smartstart.org/about-smart-start/
The UNC Center of Excellence in Maternal and Child Health Education, Science and Practice	https://sph.unc.edu/mch/center-of-excellence/
Triple P- The Positive Parenting Program	https://www.triplep-parenting.com/nc-en/find-help/triple-p-online/?itb=3ebd728de6fa78aa8bc932e9abece9c0&gclid=CjwKCAiAvriMBhAuEiwA8Cs5ITwRqDy9_GaQc9Ht-VoMHKGjs5pDURDkk0JjIwJrf5kHHvWTe98wEhoCO6EQAvD_BwE
UNC Collaborative for Maternal and Infant Health	https://www.mombaby.org/

WHAT RESULT DO WE WANT?

All people in North Carolina have long and healthy lives.

WHY IS THIS IMPORTANT?

Well-being is a complex, multifaceted, and multilayered concept. There are many different approaches to defining and measuring well-being, and the focus and terminology used to describe these measures vary. Concepts that fall within the category of well-being include psychological well-being, emotional well-being, quality of life, health-related quality of life, psychosocial functioning, thriving, flourishing, happiness, satisfaction, and others.¹

Life expectancy is one of those measures. It is also a proxy measure for the total health of a population. Disparities in life expectancy between populations point to where issues of health equity must be addressed.

HNC 2030 HEADLINE INDICATOR:

Average number of years of life remaining for people who have attained a given age

WHAT DOES THIS INDICATOR MEASURE?

Life Expectancy (LE) is the average number of additional years that someone at a given age would be expected to live if he/she were to experience throughout life the age-specific death rates observed in a specified reference period (2016-2018, 2017-2019...).

At the state level, the LEs are provided for each age interval (1) in total, and by (2) gender, (3) race (white and African American), and (4) race by gender. At the county level, the LEs are provided for each age interval (1) in total, and by (2) gender and (3) by race (white and African American). In counties with (1) a total African American population estimate of less than 1,000 or (2) any age interval African American population estimate less than 10, the LEs for African Americans are suppressed due to potential instability of the data. Race-specific county-level LEs are limited to white and African American due to issues with small numbers for other racial and ethnic categories, such as American Indians and Hispanics.

BASELINE DATA FROM HNC 2030



HOW ARE WE DOING?

- The target for *HNC 2030* is 82 years.
- The three-year average for life expectancy decreased across all race/ethnicities in 2018-2020.

CURRENT DATA TRENDED OVER TIME

Figure 84. Life expectancy across populations in North Carolina (2010 - 2020)

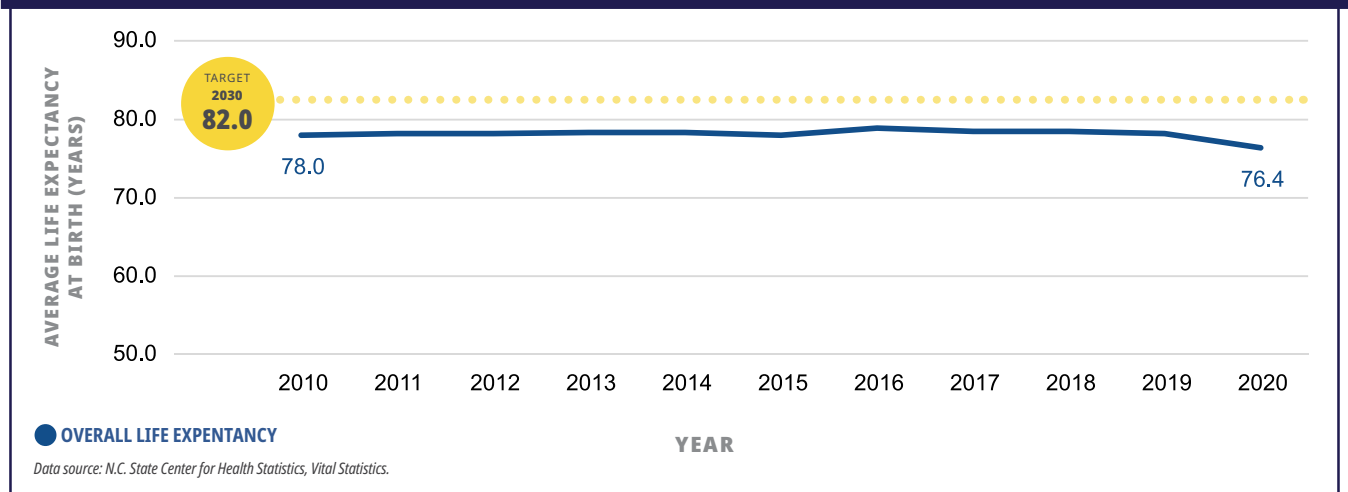


Figure 85. Life expectancy in North Carolina by race/ethnicity (2010 - 2020)

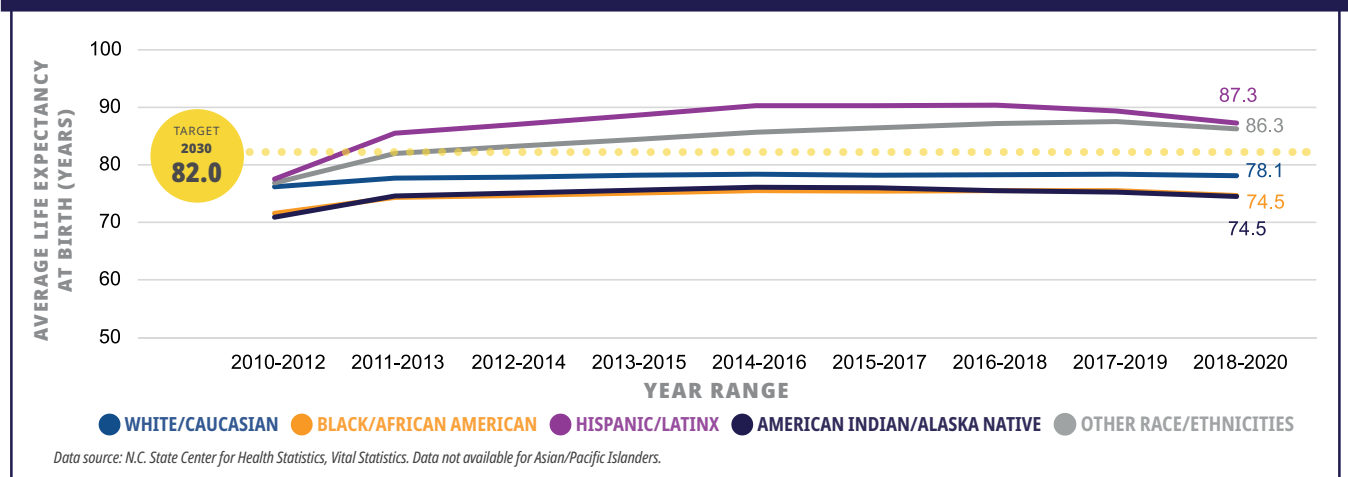
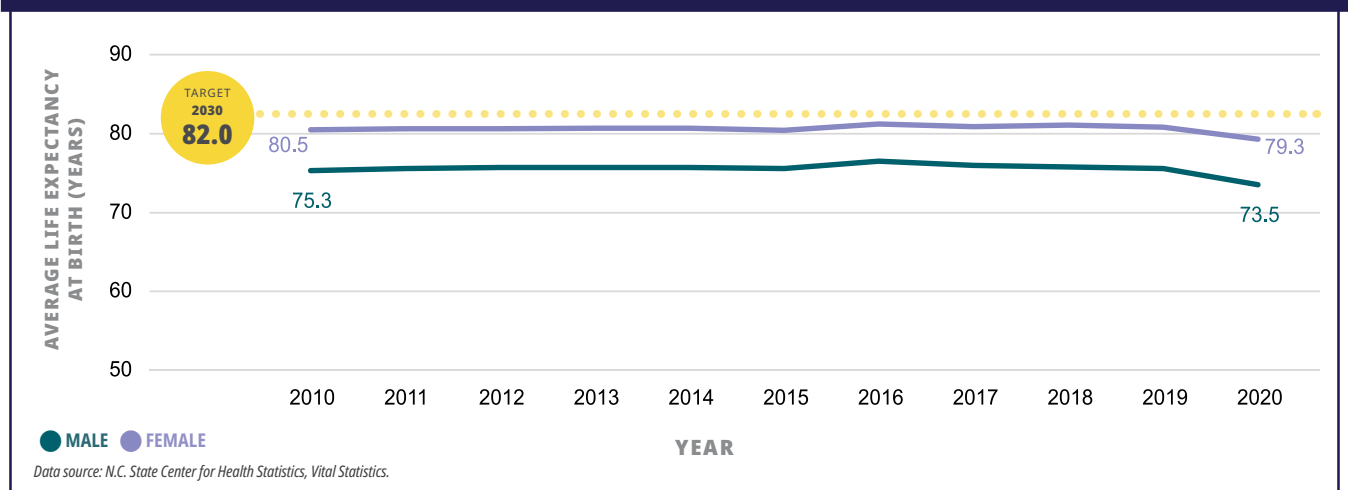


Figure 86. Life expectancy across populations in North Carolina by gender (2010 - 2020)



THE STORY BEHIND THE CURVE

Participants in the 2021 NC SHIP Community Council Meeting and Symposia discussed the following:

- “It is difficult to focus on just a few programs because many programs/initiatives/policies impact the result we want. Life expectancy is just one measure.”
- “We should examine the way we look at this measure. Living a long time and being healthy can be quite independent of each other.”
- “We need help in figuring out how to deal with small numbers.”
- “We should consider bringing in statisticians who can assist with data modeling and impute data to get more precise estimates.”
- “We need to streamline the process of obtaining data.”

Several participants recognized this indicator as an opportunity to focus on community priorities identified by partnering agencies and organizations. Two areas of interest were brain health and radon exposure. Brain health was further linked to hearing loss and falls prevention.

WHAT OTHER DATA DO WE NEED?

- Impact of COVID-19 pandemic on life expectancy
- Continuing impact of opioid epidemic on life expectancy
- Continuing impact of infant mortality on life expectancy

WHAT COULD WORK TO TURN THE CURVE?

- Assess and increase access to medical and community services for people with Alzheimer’s disease and related dementia through improved transportation services, telehealth services, and incentives for new models of care
- Build and expand key metrics, reporting, and dashboards that identify and monitor health disparities in key health outcomes to drive action and provide transparency into health equity initiatives
- Cultivate collaboration between multidisciplinary professionals to reduce falls and fall-related injuries
- Establish and fund a comprehensive, integrated state data infrastructure using a population health model to assure the timely identification, collection, analysis, integration, visualization, and dissemination of data from global, national, state, and local resources
- Foster partnerships to increase awareness of fall risk factors and advance access to fall prevention interventions
- Improve access to free radon test kits, particularly to historically marginalized populations
- Support the North Carolina Housing Finance Agency by increasing grant funds to support the installation of radon mitigation systems among homeowners financially eligible



**“THE COVID-19 PANDEMIC
UNDERScores THE URGENCY OF
WHOLE PERSON CARE... *PERHAPS AT
NO TIME IN THE MODERN HISTORY OF
THE MINDFULNESS MOVEMENT AND
CONNECTION HAS WELL-BEING PLAYED
A BIGGER ROLE THAN TODAY.*”**

- Carolyn Clancy, M.D.
Acting Deputy Secretary of Veterans Affairs

RECOMMENDED READING/LISTENING

Enhancing Well-Being Measurement in Health Research, Clinical Care, and Population Health Promotion.
<https://files.nccih.nih.gov/enhancing-well-being-measurement-meeting-june-2021-final-report.pdf>

Healthy People 2030 Overall Health and Well-Being Measures.
<https://health.gov/healthypeople/objectives-and-data/overall-health-and-well-being-measures>

NC PARTNERS WHO CAN HELP US

PARTNER/POTENTIAL PARTNER	WEBSITE LINK
American Civil Liberties Union	https://www.aclu.org/
Area Agencies on Aging	https://eldercare.acl.gov/Public/About/Aging_Network/AAA.aspx
Carolina Demography	https://www.ncdemography.org/
North Carolina Coalition on Aging	https://nccoalitiononaging.org/
NC DHHS Aging and Adult Services	https://www.ncdhhs.gov/assistance/aging-and-adult-services
North Carolina Institute For Public Health	https://sph.unc.edu/nciph/nciph-home/
Southern Coalition for Social Justice	https://southerncoalition.org/

INDICATOR #1: POVERTY

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INDICATOR #9: SEVERE HOUSING PROBLEMS

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INDICATOR #10: DRUG OVERDOSE

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Additional Reading:

Essential Actions to Address the Opioid Epidemic: A Local Health Department's Guide
<https://www.ncdhhs.gov/about/department-initiatives/opioid-epidemic/nc-essential-actions-address-opioid-epidemic-local>

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INDICATOR #11: TOBACCO USE

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Additional Reading:

Smoking Cessation: A Report of the Surgeon General <https://www.hhs.gov/sites/default/files/2020-cessation-sgr-full-report.pdf>

INDICATOR #12: EXCESSIVE DRINKING

¹ Julien, J., Ayer, T., Tapper, E.B., Barbosa, C., Dowd, W. & Chhatwal, J. (2021). Effect of increased alcohol consumption during COVID-19 pandemic on alcohol-associated liver disease: A modeling study. *Hepatology*, 75(6), 1480-1490. <https://doi.org/10.1002/hep.32272>

Additional Reading:

Report to Congress on the Prevention and Reduction of Underage Drinking 2021.
https://www.stopalcoholabuse.gov/media/ReportToCongress/2021/report_main/2021_Report_to_Congress.pdf

INDICATOR #13: SUGAR-SWEETENED BEVERAGE CONSUMPTION

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² NC SHIP 2020 – SSB

Source: CDC/Nutrition/Data and Statistics

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⁴ Rosinger, A., Herrick, K., Gahche, J., & Park, S. (2017). Sugar-sweetened Beverage Consumption Among U.S. Adults, 2011-2014. *NCHS data brief*, (270), 1–8.

⁵ Ogden, C. L., Kit, B. K., Carroll, M. D., & Park, S. (2011). Consumption of sugar drinks in the United States, 2005-2008. *NCHS data brief*, (71), 1–8.

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- ⁷ Park, S., McGuire, L. C., & Galuska, D. A. (2015). Regional Differences in Sugar-Sweetened Beverage Intake among US Adults. *Journal of the Academy of Nutrition and Dietetics*, 115(12), 1996–2002. <https://doi.org/10.1016/j.jand.2015.06.010>
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- ⁹ Kit, B. K., Fakhouri, T. H., Park, S., Nielsen, S. J., & Ogden, C. L. (2013). Trends in sugar-sweetened beverage consumption among youth and adults in the United States: 1999–2010. *The American journal of clinical nutrition*, 98(1), 180–188. <https://doi.org/10.3945/ajcn.112.057943>

Additional Reading:

Rethink Your Drink: Options for reducing the number of calories you drink

INDICATOR #14: HIV DIAGNOSIS

¹ North Carolina Department of Health and Human Services. Division of Public Health. (2021, July 29). *HIV Symposium* [work group discussion]. Eastern Area Health Education Center.

² Healthy People 2030 - Reduce the number of new HIV diagnoses – HIV-03
<https://powertodecide.org/what-we-do/information/national-state-data/north-carolina>

Additional Reading:

Ending the HIV Epidemic in the U.S.
<https://www.cdc.gov/endhiv/index.html>

INDICATOR #15: TEEN BIRTHS

¹ National Campaign to Prevent Teen and Unplanned Pregnancy, Accessed May 10, 2017, from: <https://thenationalcampaign.org/sites/default/files/resource-primary-download/fact-sheet-north-carolina.pdf>

² Perper, K., Peterson, K., Manlove, J. (2010). Diploma attainment among teen mothers. Child Trends, Fact Sheet Publication #2010-01. <https://www.childtrends.org/publications/diploma-attainment-among-teen-mothers>

³ Hoffman, SD and Maynard, RA (Eds.). (2008). Kids having kids: economic costs and social consequences of teen pregnancy (2nd ed.). Washington, DC: Urban Institute Press

Additional Reading:

The Pregnancy Risk Assessment Monitoring System (PRAMS): Overview of Design and Methodology
<https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2018.304563>

INDICATOR #16: UNINSURED

The Uninsured and the ACA: A Primer - Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act
<https://www.kff.org/uninsured/report/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act/>

The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020
<https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/>

INDICATOR #17: PRIMARY CARE CLINICIANS

¹ Healthy People 2030 - Increase the proportion of people with a usual primary care provider — AHS-07
<https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality/increase-proportion-people-usual-primary-care-provider-ahs-07>

Healthy People 2030

² Institute of Medicine. (1993). Access to health care in America <https://www.ncbi.nlm.nih.gov/pubmed/25144064>

³ Agency for Healthcare Research and Quality. (2014, May). National Healthcare Quality Report, 2013. Chapter 10: Access to Healthcare.
<https://archive.ahrq.gov/research/findings/nhqrdr/nhqr13/index.html>

⁴ Agency for Healthcare Research and Quality. (2016). 2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy. <https://www.ahrq.gov/research/findings/nhqrdr/nhqr15/access.html>

Additional Reading:

NC Health Info: Empowering Your Health Care Decisions
<https://www.nchealthinfo.org/providers-services/>

NC Medicaid/Health Choice Primary Care Providers
<https://medicaid.ncdhhs.gov/documents/medicaid-health-choice-primary-care-providers>

INDICATOR #18: EARLY PRENATAL CARE

¹ National Institute of Child Health and Human Development. (2017, January 31). What is prenatal care and why is it important? <https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/prenatal-care>

² Alexander, G. R., & Kotelchuck, M. (1996). Quantifying the adequacy of prenatal Care: A comparison of indices. *Public Health Reports*, 111(5), 408-418. <https://www.jstor.org/stable/4598042>

³ Kotelchuck, M. (1994). An evaluation of the Kessner Adequacy of Prenatal Care Index and a proposed Adequacy of Prenatal Care Utilization Index. *American Journal of Public Health*, 84(9), 1414-1420. <https://doi.org/10.1111/jmwh.12490>

⁴ Alhusen, J. L., Bower, K. M., Epstein, E., & Sharps, P. (2016). Racial discrimination and adverse birth outcomes: An integrative review. *Journal of Midwifery & Women's Health*, 61(6), 707-720. <https://doi.org/10.1111/jmwh.12490>

Additional Reading:

Insurance Differences in Preventive Care Use and Pregnant Women in a Medicaid Nonexpansion State: A Retrospective Cohort Study
<https://pubmed.ncbi.nlm.nih.gov/31397625/>

Medicaid Expansion Improves Pregnancy Outcomes for Low-income Women
<https://www.openaccessgovernment.org/pregnancy-outcomes/102698/>

NC Maternal Mental Health Matters
<https://www.med.unc.edu/ncmatters/>

Workshop on Advancing Maternal Health Equity and Reducing Maternal Mortality
<https://www.nationalacademies.org/event/06-07-2021/workshop-on-advancing-maternal-health-equity-and-reducing-maternal-mortality>

INDICATOR #19: SUICIDE

¹ Centers for Disease Control and Prevention. CDC Wonder. (2020). Underlying cause of death, 1999–2019. <https://wonder.cdc.gov/Deaths-by-Underlying-Cause.html>

² Substance Abuse and Mental Health Services Administration. (2021). Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). <https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFR1PDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf>

³ Ivey-Stephenson, A., Demissie, Z., Crosby, A., Stone, D., Gaylor, E., Wilkins, N., Lowry, R., & Brown, M. (2020). Suicidal Ideation and Behaviors Among High School Students — Youth Risk Behavior Survey, United States, 2019. *Morbidity and Mortality Weekly Report Supplement*. 69(Suppl-1), 47–55. <http://dx.doi.org/10.15585/mmwr.su6901a6>

⁴ Stone, D., Holland, K., Bartholow, B., Crosby, A., Davis, S., & Wilkins, N. (2017). Preventing suicide: A technical package of policies, programs, and practices. <https://www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf>

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⁵ Peterson, C., Sussell, A., Li, J., Schumacher, P., Yeoman, K., & Stone, D. (2020) Suicide Rates by Industry and Occupation — National Violent Death Reporting System, 32 States, 2016. *Morbidity and Mortality Weekly Report*, 69. 57–62. <http://dx.doi.org/10.15585/mmwr.mm6903a1>

Additional Reading:

2015 North Carolina Suicide Prevention Plan <https://injuryfreenc.dph.ncdhhs.gov/preventionResources/docs/2015-NC-SuicidePreventionPlan-2015-0505-FINAL.pdf>

Preventing Suicide: A Technical Package of Policy, Programs, and Practices <https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf>

INDICATOR #20: INFANT MORTALITY

¹ Pettiford, B. (2021). Maternal and infant mortality in North Carolina. *North Carolina Medical Journal* (82)3, 191-194. <https://www.ncmedicaljournal.com/content/ncm/82/3/191.full.pdf>

² Vitaglione, T. (2021, January). NC's outrageous racial gap in infant deaths persists. *NCCHILD*. <https://ncchild.org/2021-infant-mortality/#:~:text=Tom%20Vitaglione,-Senior%20Fellow%2C%20Health&text=But%20it%20may%20also%20be,5.7%20deaths%20per%201%2C000%20births>

Additional Reading:

Maternal and Infant Mortality in North Carolina
<https://www.ncmedicaljournal.com/content/ncm/82/3/191.full.pdf>

Title V Maternal and Child Health (MCH) Block Grant
<https://mchb.hrsa.gov/programs-impact/title-v-maternal-child-health-mch-block-grant>

INDICATOR #21: LIFE EXPECTANCY

¹ U.S. Department of Veterans Affairs & National Institutes of Health. (2021, June 14). Enhancing well-being measurement in health research, clinical care, and population health promotion. <https://files.nccih.nih.gov/enhancing-well-being-measurement-meeting-june-2021-final-report.pdf>

Additional Reading:

Enhancing Well-Being Measurement in Health Research, Clinical Care, and Population Health Promotion
<https://files.nccih.nih.gov/enhancing-well-being-measurement-meeting-june-2021-final-report.pdf>

Healthy People 2030 Overall Health and Well-Being Measures <https://health.gov/healthypeople/objectives-and-data/overall-health-and-well-being-measures>

HEALTHY OPPORTUNITIES SOCIAL DETERMINANTS OF HEALTH SCREENING QUESTIONS

DHHS, in partnership with a diverse set of stakeholders from across the state, developed a standardized set of Social Determinants of Health (SDOH) screening questions. <https://www.ncdhhs.gov/about/departments-initiatives/healthy-opportunities/screening-questions>

HEALTH SCREENING

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

	YES	NO
FOOD		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
HOUSING/ UTILITIES		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent (other than recreational camping), in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
TRANSPORTATION		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
INTERPERSONAL SAFETY		
7. Do you feel physically or emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
OPTIONAL: IMMEDIATE NEED		
10. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.		
11. Would you like help with any of the needs that you have identified?		

FREQUENTLY USED ACRONYMS

AAP – American Academy of Pediatrics

ACC – Accountable Care Community

ACEs – Adverse Childhood Experiences

ACOG – American College of Obstetricians and Gynecologists

BRFSS – Behavioral Risk Factor Surveillance System

CDC – Centers for Disease Control and Prevention

CNW – certified nurse midwife

EBCI – Eastern Band of Cherokee Indians

FHLI – The Foundation for Health Leadership & Innovation

FPL – Federal Poverty Level

HIV – Human Immunodeficiency Virus

HNC – Healthy North Carolina

HPV – human papillomavirus

IUD – intrauterine device

KEA – Kindergarten Entry Assessment

LARC – long-acting reversible contraceptives

LE – life expectancy

LEA – Local Education Agency

LGBTQ – lesbian, gay, bisexual, transgender, and queer

MSM – men who have sex with men

NC AHEC – NC Area Health Education Centers

NC DHHS – North Carolina Department of Health and Human Services

NC DPH – North Carolina Division of Public Health

NC DPI – North Carolina Department of Public Instruction

NC EDSS – North Carolina Electronic Disease Surveillance System

NCHA – North Carolina Healthcare Association

NCIOM – North Carolina Institute of Medicine

PA – physician assistant

PrEP – pre-exposure prophylaxis

SBIRT – Screening, Brief Intervention, and Referral to Treatment

SDOH – Social determinants of health

SHA – State Health Assessment

SNAP/EBT – Supplemental Nutrition Assistance Program/Electronic Benefits Transfer

SSB – sugar-sweetened beverage

STI – sexually transmitted infection

SUD – substance use disorder

VA – Veterans Affairs

YRBS – Youth Risk Behavior Surveillance

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HNC 2030 STATE LEVEL POPULATION HEALTH INDICATORS

(UPDATED MARCH 2022)

#	Short Title	2030 Target	Data Year	Total	W	B/AA	H/LX	O	A/PI	AI	M	F	<200%	200-399%	400% +	Data Source	
1	Poverty	27%	2020*	31.0%	23.5%	43.8%	50.2%	37.3% ^A	20.2%	47.7%	28.8	33.0%	-	-	-	American Community Survey	
2	Unemployment	Reduce unemployment disparity ratio between white and other populations to 1.7 or lower	2020*	6.4%	10.1%	13.6%	28.0%	10.9%	8.0%	15.1%	6.6%	6.3%	-	-	-	American Community Survey	
3	Short Term Suspensions	.80	2018-2019	1.50	.074	2.81	.079	1.60	.9 [†]	2.17	1.96	.73	-	-	-	NC Dept. of Public Instruction	
4	Incarceration Rate (Per 100,000)	150	2019	396	220	908	226	-	-	-	718	58	-	-	-	NC Public Safety	
5	Adverse Childhood Experiences	18.0%	2019-2020	16.6%	13.3%	22.1%	18.1%	24.9%	2.0%	-	17.8%	15.4%	-	-	-	HRSA: Children's National Health Survey	
6	Third Grade Reading Proficiency	80%	2018-2019	56.8%	70.1%	40.8%	42.6%	59.5% ^A	75.6% [†]	44.5%	54.0%	59.8%	42.6% [~]	70.6% [§]	-	NC Dept. of Public Instruction	
7	Access to Exercise Opportunities	92%	2019	74%	This measure is not appropriate for measuring progress. The data sources and definitions have changed over time, making them incomparable. We highly encourage using local data sources to track progress. One suggestion is to work with the city or county planning department to identify locations in your community that are used for physical activity and create your own measure.												CHR – Delorme, ESRI, US Census Tiger line files
8	Limited Access to Healthy Foods	5%	2015	7%	This measure is no longer ranked at CHR and has been replaced by a composite measure of the food environment which includes food insecurity and access to healthy foods.												CHR - USDA
	Food Insecurity	-	2018	14%	The Food Environment Index incorporates this indicator with a food insecurity measure.												
9	Severe Housing Problems	14.0%	2021	15% (2015-2017)	Severe housing problems is a composite measure of inadequate kitchen and bathroom facilities, overcrowding and housing cost burden. The data source does not breakdown the contribution of each component at the state, but county level data does provide 3 separate percentages.												CHR - CHAS
10	Drug Overdose Death Rate, Age Adjusted (Per 100,000)	18	2015 -2019 (total)	18.80	26.6	15.2	6.5	3.9	-	47.1	30.0	12.7	-	-	-	NC SCHS	
			2019 (disaggregated)														
			MS	10.4%	9.4%	10.2%	13.0%	10.8%	-	-	11.7%	9.0%	-	-	-	NC YTS	
			HS	27.3%	29.4%	23.5%	25.8%	27.1%	-	-	28.6%	25.7%	-	-	-	NC YTS	
11	Tobacco Use – Youth (MS/HS)	9.0%	2020	22.6%	24.4%	20.3%	14.2%	-	-	-	27.3%	18.2%	-	-	-	BRFSS/NC SCHS	
11	Tobacco Use - Adult	15.0%	2020	22.6%	24.4%	20.3%	14.2%	-	-	-	27.3%	18.2%	-	-	-	BRFSS/NC SCHS	

Retrieved from the 2020 NC State Health Improvement Plan <https://schs.dph.ncdhs.gov/units/laas/hnc.htm>

#	Short Title	2030 Target	Data Year	Total	W	B/AA	H/LX	O	A/PI	AI	M	F	<200%	200-399%	400% +	Data Source
12	Excessive Drinking	12.0%	2020	15.6%	17.1%	12.9%	15.6%	-	-	-	19.5%	11.9%	-	-	-	BRFSS/NC SCHS
13	Sugar-Sweetened Beverage Consumption - Youth	17.0%	2019	30.1%	33.6%	28.1%	25.2%	20.7%	-	-	33.6%	26.6%	-	-	-	NC Dept. of Public Instruction _YBRS
13	Sugar-Sweetened Beverage Consumption - Adult	20.0%	2019	35.4	33.7%	36.4%	44.0%	-	-	-	38.4%	32.7%	-	-	-	BRFSS/NC SCHS
14	HIV Diagnosis Rate	6.0	2020**	12.0	4.4	32.1	18.7	-	4.0	6.7	28.3	8.6	-	-	-	NC DPH EPIDEMIOLOGY
15	Teen Birth Rate	10.0	2020	17.3	11.1	23.6	31.6	5.8	-	29.5	-	-	-	-	-	NC SCHS
16	Uninsured*	8%	2020	12.9%	10.1%	13.6%	28.0%	10.9%	8.0%	15.1%	14.5%	11.3%	21.9%	11.3%	4.6%	American Community Survey
17	Access to Primary Care	25% decrease for counties above 1:1,500 provider to population	1:935													Cecil G. Sheps Center
18	Early Prenatal Care	80.0%	2020	73.1%	79.8%	66.1%	62.9%	72.4%	-	69.1%	-	-	-	-	-	NC SCHS
19	Suicide Rate (Per 100,000)	11.1	2020	13.3	17.0	6.5	5.1	9.9		7.4	13.3	5.5	-	-	-	NC SCHS
20	Infant Mortality	6.0	2020	6.9	4.8	12.8	5.8	4.2		3.3			-	-	-	NC SCHS
20	Infant Mortality B/W Disparity Ratio	1.5	2020	2.7	4.8	12.8	-	-	-	-	-	-	-	-	-	NC SCHS
21	Life Expectancy	82.0	2018-2020	76.6	78.1	74.7	87.3	86.3		74.5	73.5	79.3	-	-	-	NC SCHS

Data is the most recent data available from published websites. County Health Ranking data are expected to update in April 2022.

* 2020 data must be interpreted with caution. The US Census data cautions that the data are considered experimental and should not be used to compare with previous data.

** 2020 data should be treated with caution due to reduced availability of testing caused by the COVID-19 pandemic.

~ Economically disadvantaged as defined by NC DPI

S Not economically disadvantaged as defined by NC DPI

† Asian only

A Two or more races

B Life expectancy estimates for the Hispanic population are unstable

Retrieved from the 2020 NC State Health Improvement Plan <https://schs.dph.ncdhs.gov/units/idas/hmc.htm>

AHEC RBA TRAINING

RESULTS-BASED ACCOUNTABILITY™

DO THE RIGHT THINGS AND DO THEM WELL



Image from Clear Impact



LIVE WEBINARS

Nov. 30, Dec. 1-2, 2021
Eastern AHEC

Jan. 11-13, 2022
Area L AHEC

Feb. 15-17, 2022
Charlotte AHEC

March 1-3, 2022
Southern Regional AHEC

March 22-24, 2022
Wake AHEC

April 12-14, 2022
South East AHEC

May 3-5, 2022
Mountain AHEC

May 24-26, 2022
Northwest AHEC

June 7-9, 2022
Greensboro AHEC



NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES



RESULTSNC

Provided by North Carolina Area Health Education Centers (NC AHECs)
In collaboration with the NC DHHS/Division of Public Health (DPH)
and the Foundation for Health Leadership & Innovation (FHLI)

Results-Based Accountability™

Results-Based Accountability™ (RBA) is a disciplined way of thinking and acting to improve entrenched and complex social problems. Communities use RBA to improve the lives of children, youth, families and adults. It is also used by organizations to improve the effectiveness of their programs and services.

This RBA curriculum is developed by the NC AHECs, in collaboration with DPH and FHLI to build RBA capacity in North Carolina. [Healthy North Carolina 2030 \(HNC 2030\)](#) and the [North Carolina State Health Improvement Plan \(NC SHIP\)](#) inform the activities and the examples used in this course. Participants will gain knowledge in the RBA framework and skill in applying key concepts.

Credit

CHES®/MCHES®

Application for CHES® (entry-level) / MCHES® (advanced level) Category I continuing education contact hours (CECH) has been made to the National Commission for Health Education Credentialing, Inc. (NCHEC).

Other Professionals

10.0 AHEC Contact Hours will be awarded for participants who attend 90% of the workshop.

CEUs

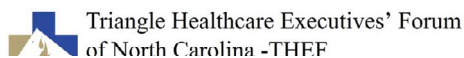
1.0 CEUs will be awarded for participants who attend 90% of the workshop.

**Note: Eastern AHEC and South East AHEC do not provide CEUs for activities.*

Certificates will be awarded after the participant completes the evaluation.

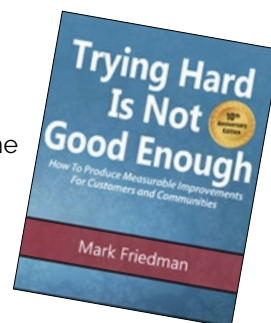
ACHE

As an independent chartered chapter of the American College of Healthcare Executives, Triangle Healthcare Executives' Forum of North Carolina (THEF) is authorized to award 10 hours of ACHE Qualified Education credit toward advancement or recertification in the American College of Healthcare Executives. Participants in this program who wish to have it considered for ACHE Qualified Education credit should list their attendance when they apply to the American College of Healthcare Executives for advancement or recertification.



"Trying Hard is Not Good Enough" by Mark Friedman

A copy of the book will be provided to all participants. Familiarizing yourself with the book, especially chapters one and two, will accelerate your learning. Participants are encouraged to register early in order to receive the book prior to the course.



Who Should Attend

People who lead and support initiatives to improve the lives of people in North Carolina, including community-based organizations, healthcare systems, health departments, community activists, and others.



Due to the participatory nature of this workshop, a computer with audio and video capabilities is required.

Objectives

At the completion of this course, participants will be able to:

- Describe the core concepts of Results Based Accountability™.
- Distinguish between population indicators and program performance measures.
- Apply turn-the-curve thinking to equity-centered community health work.

PHOTOGRAPHY SOURCES

Housing Projects, By Jose Luis Stephens [Photograph] #471475326
Retrieved 2022, from: <https://stock.adobe.com/471475326>

Page 31

Focused diverse students discuss ideas studying in class together, By fizkes [Photograph] #281404840
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Page 39

Barbed wire fence, By tomas [Photograph] #171240570
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The background of the outdoor exercise facility, By bangprik [Photograph] #345333799
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Doctor hands holding Purple ribbons, By sewcream [Photograph] #221389347
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Uninsured red circle, By zimmytw [Photograph] #83930875
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Page 97

Hand turns dice and changes the expression “no care” to “health care”, By Fokusi [Photograph] #1249188236
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Pregnant women in a class, By Rawpixel.com [Photograph] #203325337
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Young interracial family with little children at home, By Halfpoint [Photograph] #159330615
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Senior Couple Putting On In Line Skates In Park, By Monkey Business [Photograph] #119536342
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HEALTHY NORTH CAROLINA 2030

ARTISTIC SKETCH ACTIVITY

When helping partners come up with solutions for the *wicked problems* within our communities, we have found it helpful to use an activity where we imagine what a truly healthy North Carolina could look like!

We realize that it can be challenging to imagine the possibilities for a healthier world and to engage in positive thinking. The following activity is designed to help community partners to imagine a community in which they would like to live and work.

The activity is used in the RBA course taught by NC AHEC.

THE ACTIVITY

1. Spend a few minutes looking at the artwork on the next two pages.
2. Think of the artwork as a map of North Carolina.
3. Identify positive objects in the communities represented in the artwork.
4. Visit the last page for a Sketch Key list and compare your positive objects/ideas to imagine a healthier North Carolina!



The talented artist creating the original artwork for the course is:

Kim Ballentine of Kimberly Ballentine Fine Art
Raleigh/New Bern, North Carolina





NC ARTISTIC SKETCH KEY

TOP LEFT QUADRANT

- Accessibility
- Air Travel
- Apple Farm
- Bee Keeping
- Biking
- Community Park
- Education/School
- Faith Community
- Green Spaces
- Greensboro/Main Street
- Grocery Store/Market
- Highway Infrastructure
- Hiking
- Housing
- Mass Transit/City Bus
- Mixed Development Urban Area
- Museum - Indigenous People
- NC Zoo
- Playground
- Parkway
- Recreation Center/Gym
- River Rafting
- Skiing
- Solar Energy
- Tree Farm
- Walkable Community/Sidewalks
- Multigenerational communities

TOP RIGHT QUADRANT


- Academic Center/Research
- Bee Keeping
- Biking
- Camping
- Chicken Farm
- City Farm/Community Garden
- Crosswalks/Accessibility
- Emergency Services
- Ferry
- Fishing
- Golf Course
- Green Spaces
- Housing
- Mass Transit/City Bus/Train
- Medical Center/Hospital
- Pets
- Recreational Opportunities/Tourism
- Sailing/Canoeing
- State Capital/Government
- Walkable Community/Sidewalks
- Wind Energy

BOTTOM LEFT QUADRANT

- Biking
- Charlotte/NoDa District
- Clean Waterways
- Community Safety
- Crosswalks/Accessibility
- Education/School
- Electric Vehicles/Charging
- Station
- Emergency Services
- Green Spaces
- Highway Infrastructure
- Housing
- Industrial Warehouses
- Mass Transit/City Bus
- Military
- Mixed Development Urban Area
- Multicultural Communities
- Playground
- River Rafting
- Theater
- Walkable Community/Sidewalks

BOTTOM RIGHT QUADRANT

- Accessibility
- Agricultural Field/Community Garden
- Biking
- Child Care
- Clean Waterways
- Education/School
- Faith Center
- Green Spaces
- Health Center
- Housing
- Multicultural Communities
- Playground
- Recreational Opportunities/Tourism
- Swimming/Water Sports
- Transportation
- Walkable Community/Sidewalks
- Wilmington/Waterfront District



For more information about *Healthy North Carolina 2030*,
the *North Carolina State Health Improvement Plan*,
or the NC State Health Improvement Scorecard,
please contact the *HNC 2030* Resource Center

HNC2030@dhhs.nc.gov

or visit

<https://schs.dph.ncdhhs.gov/units/las/hnc.htm>

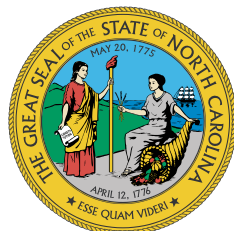
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